SUMMARY DESCRIPTION
OF THE
South St. Paul Schools
CAFETERIA PLAN

Effective January 1, 2019

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INTRODUCTION

Your employer, South St. Paul Schools ("Employer"), is pleased to sponsor an employee benefit program known as the South St. Paul Schools Cafeteria Plan (the " Cafeteria Plan") for its employees. Under federal tax laws, it is also known as a "cafeteria plan." The Employer provides you with the opportunity to use pre-tax dollars to pay certain benefit costs by entering into a salary reduction arrangement. This arrangement helps you because many of the benefits you elect are nontaxable; you should save social security and income taxes on the amount of your salary reduction.

This summary describes the basic features of the Cafeteria Plan, how it operates, and how you can get the maximum advantage from it. To make use of this Cafeteria Plan, be sure to proceed through this booklet carefully so that you can make informed decisions that are right for you.

This document is only a summary of the key parts of the Cafeteria Plan and a brief description of your rights as a Participant. If there is a conflict between the underlying plan document and this summary, the intention is for the plan document to govern. If you have any questions after reading this summary, please contact the Plan Administrator at the number listed in the Administrative Information section of this summary.

PART I.
GENERAL INFORMATION ABOUT THE PLAN

1.1 What is the purpose of the Cafeteria Plan?

The purpose of the Cafeteria Plan is to allow eligible employees to use funds provided through employee salary reduction to choose (and pay for) certain benefits made available by the Employer.

1.2 When did the Cafeteria Plan take effect?

This Plan originally became effective January 1, 1990. This restatement is effective January 1, 2019.

The Plan operates on a Plan Year running from January. What Optional Benefits are offered through the Cafeteria Plan?

This Plan makes the following "Optional Benefits" available:

Group Premiums:

- Group Medical Benefits
  - The group medical benefit allows a Participant to pay the employee's share of the cost for medical coverage made available by the Employer with pre-tax dollars through salary reduction.
- Group Dental Benefits
  - The group dental benefit allows a Participant to pay the employee's share of the cost for dental coverage made available by the Employer with pre-tax dollars through salary reduction.
- Group Term Life Benefits and/or Group AD&D Benefits
  - The group term life benefit allows a Participant to pay the employee's share of the cost for group term life insurance coverage made available by the Employer with pre-tax dollars through salary reduction.
  - The accidental death and dismemberment benefit allows a Participant to pay the employee's share of the cost for group accidental death and dismemberment coverage made available by the Employer with pre-tax dollars through salary reduction.

Other:

- Dependent Care Flexible Spending Account
  - The dependent care reimbursement benefit allows a Participant to fund an account with pre-tax dollars through salary reduction that may be used to reimburse the Participant for eligible dependent care expenses.
- Health Flexible Spending Account
  - The medical expense reimbursement benefit allows a Participant to fund an account with pre-tax dollars through salary reduction which may be used to reimburse the Participant for eligible medical expenses.
- Limited Scope Health Flexible Spending Account
  - The limited scope medical expense reimbursement benefit allows a Participant to fund an account with pre-tax dollars through salary reduction which may be used to reimburse the Participant for limited medical expenses. It is made available for Participants wishing to make or receive

contributions to a health savings account.

- HSA Contribution Feature
  - The HSA contribution feature allows a Participant to make contributions to an HSA.

1.3 Who can participate in the Cafeteria Plan?

Each employee who (a) is employed thirty (30) hours or more per week, and (b) has been employed through the first of the month following date of hire is eligible to participate in the Cafeteria Plan. In addition, any Employee who is eligible for group health or accident coverage that is an Optional Benefit shall be eligible to participate in the Plan solely for purpose of paying premiums for that Optional Benefit regardless of whether he/she satisfies the foregoing eligibility requirements. These employees are called "Eligible Employees." Those Eligible Employees who actually participate in the Cafeteria Plan are called "Participants." There are certain exceptions. They are described in the underlying Plan document. You will be notified if you fall within one of the exceptions.

"**Employee**" means a common-law employee of the Employer who is on the Employer's W-2 payroll, except that the term "Employee" does not include any common-law employee who is a leased employee (including, but not limited to, an individual defined in Internal Revenue Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for benefits as provided hereunder after an employee ceases to be employed by the Employer.

1.4 When do I become a Participant and how long does participation last?

For newly eligible Employees, participation may begin on the first of the month following date of hire or, if later, the first day of the first pay period following your completion and submission of any required enrollment forms. If they are required, you must submit the enrollment forms within the time period established and communicated to you by the Plan Administrator.

NOTE: With respect to group premiums, if you have enrolled in those benefits, you may automatically become a Participant in this Cafeteria Plan as described in Section 1.6.

A special rule applies to new hires. Notwithstanding the foregoing, if you enroll within thirty (30) days following your date of hire, your enrollment will be effective as of your date of hire. Any salary reduction contributions covering this retroactive coverage period will be taken from compensation earned after you complete and submit the enrollment forms.

If you do not become a Participant when first eligible, you may become a Participant at the start of any subsequent Plan Year.

As a condition to participation in the Cafeteria Plan, you must also:

(a) observe all Plan rules and regulations;

(b) agree to inquiries by the Plan Administrator with respect to any physician, hospital, or other provider of medical care or other services covered by this Cafeteria Plan;

(c) submit to the Plan Administrator all notifications, reports, bills, and other information that the Employer may reasonably require; and

(d) agree to repay any overpayments or incorrect payments you receive from the Cafeteria Plan.

Participation continues until you elect not to participate, you are no longer an Eligible Employee, the Cafeteria Plan terminates, your contributions cease, or your participation is terminated for cause.

1.5 How do I enroll and make benefit elections?

(a) **Generally**. The Plan Administrator will provide you with the forms necessary to enroll and make elections, including information about the costs of the various Optional Benefits.

(b) **Initial Enrollment**. If you become an Eligible Employee other than at the start of a Plan Year, the initial enrollment period takes place at the time you become eligible to participate as described in Section 1.5. If you do not make an election during the initial enrollment period, you must generally wait until the next annual enrollment period to begin participation. However, if you have enrolled in the Group Medical Plan, Group Dental Plan, Group Term Life and AD&D Plan, Flexible Spending Account, Limited Scope Flexible Spending Account, Dependent Care Flexible Spending Account and HSA Contribution Feature, you will be deemed to have elected to pay through salary reduction any portion of the cost for which you are responsible under such plans. This will occur unless you specifically elect not to participate with respect to such coverage. Such an election must be in writing and must be received by the Plan Administrator prior to the date your participation in the Cafeteria Plan would otherwise begin.

(c) **Annual Enrollment**. The annual enrollment period for the coming Plan Year begins and ends on or before the last day of each Plan Year. If you do not make an election during the annual enrollment period, you will be deemed to have elected to not participate in the Cafeteria Plan. However, if you have enrolled in the Group Medical Plan, Group Dental Plan, Group Term Life and AD&D Plan, Flexible Spending Account, Limited Scope Flexible Spending Account, Dependent Care Flexible Spending Account and HSA Contribution Feature you will be deemed to have elected to pay through salary reduction any portion of the cost for which you are responsible under such plans. This will occur unless you specifically elect not to participate with respect to such coverage. Such an election must be in writing and must be received by the Plan Administrator prior to the first day of the Plan Year.

NOTE: Enrollment forms received after the close of the enrollment period shall be void.

CAUTION: With limited exceptions, once made, elections remain in effect for the entire Plan Year. The exceptions are described below at Question 1.8.

1.6 What is the maximum election I can make under the Cafeteria Plan?

The maximum salary reduction election available under this Cafeteria Plan is the sum of your cost of coverage under the Group Medical Plan, Group Dental Plan, Group Term Life and AD&D Plan, the cost of any eligible individual Insurance Contracts and the maximum election permitted under the Health Flexible Spending Account, Limited Scope Health Flexible Spending Account, Dependent Care Flexible Spending Account, and the HSA Contribution Feature minus any Employer contribution.

1.7 Can I change my election during the Plan Year?

Generally, you cannot change your election regarding participation in the Cafeteria Plan or the Optional Benefits you have selected under the Cafeteria Plan during the Plan Year. You may change your elections only during the annual enrollment period, and then, only for the coming Plan Year. However, your elections will terminate automatically if you cease to be eligible to participate in the Cafeteria Plan. In addition, there are several other exceptions to this general rule.

Caution: The circumstances in which you are allowed to change your election, as further described below, are based upon the facts and circumstances of each particular situation. The descriptions of the rules below are general in nature. If you have questions regarding the application of the rules to your specific fact situation, please contact the Plan Administrator immediately. Any request to change your election must be within the deadline described below.

NOTE: The exceptions to the general rule that elections are irrevocable for the Plan Year are determined under regulations issued by the IRS.

NOTE: The IRS recognizes only marriages that are valid under applicable state law. Accordingly, a reference to marital status or spouse in this Section 1.8 is applicable only if you are married to an individual and the marriage is valid under applicable state law.

NOTE: For purposes of this Section 1.8, if the election relates to an Optional Benefit involving health benefits (e.g., Group Medical Plan, Group Dental Plan, Group Term Life and AD&D Plan, Flexible Spending Account, Limited Scope Flexible Spending Account, Dependent Care Flexible Spending Account and HSA Contribution Feature), the term "dependent" means a "tax dependent" as defined below in Section 1.16. If the election relates to the Dependent Care Flexible Spending Account, the term "dependent" means a "qualifying individual" as defined below in Section 3.5.

(a) **Change in Status.** You may change or revoke your previous election during the Plan Year if one or more of the following changes in status occur:

(1) a change in your legal marital status, including marriage, divorce, death of your spouse, legal separation or annulment;

NOTE: A change in the status of a domestic partnership is not a change in status.

(2) a change in the number of your dependents, including birth of a child, adoption or placement for adoption of a dependent, or death of a dependent;

(3) any of the following events that change your employment status or the employment status of your spouse or dependent: termination or commencement of employment, a reduction or increase in hours worked, a switch between part-time and full-time, a strike or lockout, a change in worksite, commencement or

return from an unpaid leave of absence, a switch between hourly and salaried, a switch between union and non-union, or any similar event;

(4) an event causing a dependent to satisfy or cease to satisfy the eligibility requirements applicable under a plan provided or paid for through this Cafeteria Plan; or

(5) a change in place of residence for you, your spouse or your dependent.

A change or revocation shall be allowed in these circumstances only if such change or revocation is made on account of, and corresponds with, the change in status and the change in status affects eligibility for coverage under a plan sponsored by the Employer or another employer (referred to as the general consistency requirement). The Plan Administrator (in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change or revocation satisfies the general consistency requirement.

Example 1: An employee enrolls in single coverage under the Employer's Group Medical Plan and elects to pay the cost of that coverage through the Cafeteria Plan. The employee also elects to participate in the Health Flexible Spending Account. During the Plan Year, the employee gets married. If the employee enrolls his or her new spouse in the Group Medical Plan, the employee may change his or her election to pay the increased cost of that coverage through the Cafeteria Plan. In addition, the employee may increase his or her election under the Health Flexible Spending Account.

Example 2: Employer has three medical plan options: an indemnity option, an HMO option with a service area covering the location of one of Employer's operations, and an HMO option with a service are covering the location of the other operation. An employee enrolls in the HMO option with a service area covering the area in which employee works and makes an election to pay the cost of the coverage through the Cafeteria Plan. Employee also elects to participate in the Health Flexible Spending Account. If employee is transferred to the other location, the employee may switch to the other HMO option or the indemnity option and change his or her election to pay the cost of the new option. The employee may also drop medical coverage and terminate his or her election under the Cafeteria Plan to pay the cost of medical coverage. The employee cannot change his or her election under the Health Flexible Spending Account because the change in work location does not affect his or her eligibility under the Health Flexible Spending Account.

A requested change or revocation must also satisfy the following specific consistency requirements in order for you to be able to alter your election based on the change in status:

(1) **Loss of Dependent Eligibility.** For a change in status involving your divorce, annulment or legal separation from your spouse, the death of your spouse or dependent, or your dependent ceasing to satisfy the eligibility requirements for coverage, you may elect to change your election only to reflect the cancellation of group health plan coverage for the affected spouse or dependent. Canceling coverage for any other individual under these circumstances fails to correspond with that change in status. For example, if you have elected group medical coverage for you, your spouse, and your child, and you divorce during the Plan Year, you may drop your ex-spouse from the coverage and make an election change under this Cafeteria Plan to reflect the reduced cost of coverage. However, you would not be allowed to change your election to reflect the reduced cost attributable to dropping coverage for yourself or your child.

(2) **Gain of Coverage Eligibility Under Another Employer's Plan**. If you, your spouse, or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital status or a change in employment status, you may elect to terminate or decrease your election under this Cafeteria Plan on account of that change in status only if coverage becomes effective or is increased under the other employer's plan.

(3) **Dependent Care Flexible Spending Account**. With respect to the Dependent Care Flexible Spending Account, you may change or terminate your election only if (i) the change or termination is made on account of and corresponds with a change in status that affects eligibility for coverage under the Flexible Benefit Dependent Care Flexible Spending Account; or (ii) the election change is on account of and corresponds with a change in status that affects eligibility of dependent care expenses for the tax exclusion available under the Internal Revenue Code. For example, if your child attains age 13 during the Plan Year, you may terminate your election under the Dependent Care Flexible Spending Account because your child is no longer eligible to participate in the Dependent Care Flexible Spending Account (i.e., she is no longer a qualifying individual).

(4) **Group Term Life Insurance and Disability Coverage**. For a change of status involving your legal marital status or the employment status of your spouse or dependent, you may increase or decrease the amount of your group term life insurance and/or disability coverage and change your election under the Cafeteria Plan to pay the increased or decreased cost of such coverage without regard to the requirement that the event cause a loss or gain of eligibility.

(5) **COBRA Coverage**. If you, your spouse, and/or your dependent elects COBRA continuation coverage (or similar health plan continuation coverage under state law) with respect to a group health plan sponsored by the Employer, you may increase your election for the purpose of paying the cost of the increased premium for such continuation coverage, provided you are still eligible under the Cafeteria Plan and are receiving compensation from the Employer.

(b) **Other Change in Election Events.** You may also change or revoke your previous election during the Plan Year in the following circumstances.

(1) **HIPAA Special Enrollment Rights**. In certain cases, individuals are allowed to enroll in the Employer's Group Medical Plan pursuant to HIPAA special enrollment at times other than open enrollment. Generally, special enrollment is available upon: (i) acquiring a new spouse or dependent, (ii) losing other group coverage, (iii) losing coverage under Medicaid or a state children's health insurance program ("SCHIP"), and (iv) becoming eligible for a subsidy under Medicaid or SCHIP for coverage under the Employer's group health plan. (Please refer to the plan documentation for the Group Medical Plan for additional information regarding HIPAA special enrollment, including information regarding the situations in which special enrollment is available and the deadline for requesting special enrollment under that plan.)

If you, your spouse, and/or your dependent actually enroll in the Group Medical Plan pursuant to HIPAA special enrollment, then you may make a new election under the Cafeteria Plan to pay the cost of that new or increased coverage. For purposes of this provision an election to add previously eligible dependents as a

result of the acquisition of a new spouse or dependent child (a/k/a the Tag-along Rule), shall be considered consistent with the special enrollment right.

Note: There are two separate steps involved in making an election change under this exception. You and/or your spouse and dependents must enroll in the Group Medical Plan within the HIPAA special enrolment time period required under that plan. If such enrollment in the Group Medical Plan changes your share of the cost of coverage, you must also request a change to your election under the Cafeteria Plan in accordance with paragraph (h) below. The time period described in paragraph (h) begins to run on the effective date of the special enrollment in the Group Medical Plan. It is the coverage attributable to the HIPAA special enrollment that triggers the need to change election under the Cafeteria Plan.

(2) **Certain Judgments, Decrees and Orders**. If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires you to cover your child (including a foster child who is your dependent) under the Group Medical Plan, Group Dental Plan, Group Term Life and AD&D Plan, Flexible Spending Account, Limited Scope Flexible Spending Account, Dependent Care Flexible Spending Account and HSA Contribution Feature, you may change your election to pay the increased cost of coverage incurred to add the dependent child to your coverage. If an Order requires another individual to provide health coverage for your child (including a foster child who is your dependent) and the child is currently enrolled in the Group Medical Plan, Group Dental Plan, Group Term Life and AD&D Plan, Flexible Spending Account, Limited Scope Flexible Spending Account, Dependent Care Flexible Spending Account and HSA Contribution Feature, you may terminate coverage for the child and change your election to reflect the reduced cost of coverage (if any), provided the other individual actually provides coverage to the child as required by the Order. For example, if you have enrolled in single coverage under the Group Medical Plan, become divorced during the Plan Year, and are ordered to provide coverage to your child following the divorce, you may increase your election to pay the additional cost of the child's coverage under the Group Medical Plan.

(3) **Medicare and Medicaid**. If you, your spouse, or your dependent is enrolled in the Group Medical Plan, Group Dental Plan, Group Term Life and AD&D Plan, such individual subsequently enrolls in Medicare or Medicaid, and such individual's coverage under the Employer's plan is cancelled, you may change your election to reflect the reduced cost of coverage (if any) under the applicable Employer-sponsored group health plan. You may also reduce or cancel your election with respect to the Flexible Spending Account, Limited Scope Flexible Spending Account, Dependent Care Flexible Spending Account and HSA Contribution Feature. Further, if you, your spouse, or your dependent has been enrolled in Medicare or Medicaid, such individual loses eligibility for such coverage, and such individual enrolls in the Group Medical Plan, Group Dental Plan, Group Term Life and AD&D Plan, you may change your election to reflect the increased cost of coverage (if any) under the applicable Employer-sponsored group health plan. You may also make or increase your election with respect to the, Flexible Spending Account, Limited Scope Flexible Spending Account, Dependent Care Flexible Spending Account and HSA Contribution Feature.

NOTE: Certain changes to an individual's Medicaid coverage also create a HIPAA special enrollment right. Election changes based upon HIPAA special enrollment rights are described above.

(c) **Change in Cost**.

NOTE: Although the Plan Administrator will be aware of an increase or decrease in the cost of many Optional Benefits, you will need to notify the Plan Administrator of any changes to the cost of benefits under the Dependent Care Flexible Spending Account.

NOTE: This exception does not allow changes to your election under the Health Flexible Spending Account and the Limited Scope Health Flexible Spending Account. Furthermore, this exception does not apply to the Dependent Care Flexible Spending Account if the dependent care provider is your relative.

(1) **Automatic Increase or Decrease for Insignificant Cost Changes**. If the cost of coverage increases or decreases during a Plan Year by an insignificant amount, then your election to pay the cost of such coverage through the Cafeteria Plan shall be automatically increased or decreased to reflect such change in the cost. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether increases or decreases in costs are "insignificant" based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).

(2) **Significant Cost Increases**. If the Plan Administrator determines that the cost of coverage significantly increases during a Plan Year, you may either: (i) increase your election to pay the additional cost, (ii) enroll in another benefit package option providing similar coverage and change your election (if necessary) to pay the cost of that option through the Cafeteria Plan, or (iii) cancel the underlying coverage and revoke your election to pay the cost of that coverage through the Cafeteria Plan if no other benefit package option providing similar coverage is available. For example, if the cost of one option under the Group Medical Plan significantly increases during the Plan Year, you may increase your election to pay the increased cost or enroll in another option available under the Group Medical Plan and change your election to correspond to the new cost of Group Medical Plan coverage. If there is only one Group Medical Plan option, you may increase your election to pay the increased cost of that option or cancel Group Medical Plan coverage and revoke your election to pay for that coverage through the Cafeteria Plan. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and what constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(3) **Significant Cost Decrease.** If the Plan Administrator determines that the cost of coverage significantly decreases during a Plan Year: (i) you may enroll in the coverage and make or change your election to pay the cost of such coverage through the Cafeteria Plan; or (ii) if you are already enrolled in the underlying coverage and are paying the cost of such coverage through the Cafeteria Plan, the Plan Administrator will automatically decrease your election to pay the cost of such coverage in accordance with the cost decrease.

For purposes of this rule, a change in cost allowing an election change can result from action taken by you (e.g., switching between full-time and part-time employment) or your

Employer (e.g., changing the amount of Employer contribution toward the cost of coverage).

(d) **Change in Coverage**.

NOTE: This exception does not allow changes to your election under the Flexible Spending Account, Limited Scope Flexible Spending Account, Dependent Care Flexible Spending Account and HSA Contribution Feature.

(1) **Significant Curtailment**. If the Plan Administrator determines your coverage, or the coverage of your spouse or dependent, is significantly curtailed during a Plan Year, you may enroll in another benefit package option providing similar coverage and make a corresponding election change to pay for that new coverage through the Cafeteria Plan. Coverage is "significantly curtailed" only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to all participants in general (e.g., a significant increase in the deductible, copays, or out-of-pocket maximum applicable under the plan). The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a benefit package option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(2) **Loss of Coverage.** If the Plan Administrator determines that your coverage, or the coverage of your spouse or dependent, is lost during a Plan Year, you may: (i) enroll in another option providing similar coverage and make a corresponding election change to pay for that new coverage through the Cafeteria Plan, or (ii) if no other option providing similar coverage is available, cancel the underlying coverage and revoke your election to pay the cost of such coverage through this Cafeteria Plan. Coverage is deemed "lost" only if there is a complete loss of coverage (e.g., the benefit plan option is eliminated or an annual or lifetime maximum is reached) or other fundamental loss of coverage (e.g., a substantial decrease in the health care providers available under the option or a reduction in benefits for a specific type of medical condition with respect to which you or your spouse or dependent is currently receiving treatment. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a "loss" has occurred, and whether a benefit package option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

Application to Dependent Care Flexible Spending Account. This rule allows you to change your election under the Dependent Care Flexible Spending Account to reflect changes regarding your dependent care provider, including: (1) the termination of one provider and the hiring of another provider, and (2) the termination of a provider because a relative becomes available to care for your child at no cost. You will need to notify the Plan Administrator of any such change in coverage under the Dependent Care Flexible Spending Account.

(3) **Addition or Improvement of an Optional Benefit**. If during a Plan Year, a new plan or plan option is offered, or if coverage under an existing plan or option is significantly improved, you may enroll in the new or improved coverage and make or change your election to pay the cost of such coverage through the Cafeteria Plan. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether an Optional Benefit has been "significantly improved" based upon all the surrounding facts and circumstances.

(4) **Change Under Another Employer-Sponsored Plan**. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including a plan of the Employer or a plan of another employer) if: (i) the other plan permits its participants to make an election change that would be permitted under the prevailing IRS guidance, or (ii) the Plan Year of this Cafeteria Plan is different from the plan year under the other plan. For example, if your spouse drops your coverage during open enrollment under his or her employer's group medical plan and you enroll in the Employer's Group Medical Plan, you may make or change your election to pay for such coverage through the Cafeteria Plan.

(5) **Loss of Governmental or Educational Coverage**. If you add coverage under an Employer-sponsored group health plan (e.g., Group Medical Plan, Group Dental Plan, Group Term Life and AD&D Plan, Flexible Spending Account, Limited Scope Flexible Spending Account, Dependent Care Flexible Spending Account and HSA Contribution Feature) for yourself or your spouse or dependent because such individual has lost coverage under any health coverage sponsored by a governmental or educational institution (including, but not limited to, the following: a state children's health insurance program ("SCHIP"), a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government health plan), you may make or change your election to pay the cost of such coverage under the Cafeteria Plan.

NOTE: Certain changes to an individual's coverage under a state children's health insurance program ("SCHIP") also create a HIPAA special enrollment right. Election changes based upon HIPAA special enrollment rights are described above.

(6) **Enrollment in Marketplace Coverage.**

(A) If you have made an election to pay for Group Medical Plan coverage, you may revoke that election if the following conditions are satisfied:

(i) You either (1) are eligible to enroll in a qualified health plan through a public insurance exchange (the "Marketplace") via a special enrollment period (as provided in any guidance issued by the Department of Health and Human Services or any other applicable guidance), or (2) seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(ii) You cancel coverage under the Group Medical Plan in accordance with the requirements of that plan; and

(iii) You, and any related individuals who were also enrolled in the Group Medical Plan, have enrolled in or intend to enroll in a qualified health plan through the Marketplace that will be effective no later than the day immediately following the last day for which coverage under the Group Medical Plan was effective (i.e., there is no break in coverage). The Plan Administrator may rely on your reasonable representation that the requirements of this paragraph (iii) are met.

(B) If you have made an election to pay for Group Medical Plan coverage, you may reduce that election if the following conditions are satisfied:

(i) Your spouse and/or dependents either (1) are eligible to enroll in a qualified health plan through the Marketplace via a special enrollment period (as provided in any guidance issued by the Department of Health and Human Services or any other applicable guidance), or (2) seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(ii) You cancel coverage under the Group Medical Plan for such spouse and/or dependents in accordance with the requirements of that plan; and

(iii) Such spouse and/or dependents have enrolled in or intend to enroll in a qualified health plan through the Marketplace that will be effective no later than the day immediately following the last day for which the coverage under the Group Medical Plan was effective (i.e., there is no break in coverage). The Plan Administrator may rely on your reasonable representation that the requirements of this paragraph (iii) are met.

(e) **Reduction in Hours Without Loss of Eligibility.** If you have made an election to pay for Group Medical Plan coverage, you may revoke that election if the following conditions are satisfied:

(1) You have been in an employment status under which you were reasonably expected to average at least thirty (30) hours of service per week;

(2) You have experienced a change in employment status such that you will reasonably be expected to average less than thirty (30) hours of service per week after the change but nevertheless will remain eligible for the Group Medical Plan;

(3) You cancel coverage under the Group Medical Plan in accordance with the requirements of that plan; and

(4) You, and any related individuals who were also enrolled in the Group Medical Plan, have enrolled or intend to enroll in other medical coverage that provides minimum essential coverage and that will be effective no later than the first day of the second month following the month in which coverage under the Group Medical Plan ends. The Plan Administrator may rely on your reasonable representation that the requirements of this paragraph (4) are met.

(f) **Family and Medical Leave Act.** If you take a leave governed by the Family and Medical Leave Act of 1993 ("FMLA"), you may revoke or change an election as may be provided for under the FMLA and the Employer's FMLA policy required thereunder, provided the Employer is subject to FMLA.

(g) **Special Rule for HSA Contribution Feature**. You may change your election with respect to the HSA Contribution Feature prospectively on at least a monthly basis. You may also revoke your election with respect to the HSA Contribution Feature prospectively

if you become ineligible to make or have made HSA contributions under the HSA Contribution Feature.

(h) **Other**. The Plan Administrator shall have the discretion to allow a change to, or termination of, an election to the extent such change or termination is the result of any other situation informally recognized by the IRS as providing an exception to the general rule that elections are irrevocable (e.g., corrections of mistakes, failure to satisfy underwriting). If the Plan Administrator determines before or during any Plan Year the Cafeteria Plan or an Optional Benefit may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code or other applicable law, the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a modification of your election downward with or without your consent.

(i) **Procedure for Requesting a Change.** If a change in election is allowed under the foregoing rules, you must typically inform the Plan Administrator of your new election within thirty (30) days of the occurrence of the event allowing the change. Your election change must be on account of and consistent with the status change that has occurred. In general, that means the event must result in a change in coverage that changes the cost. Subject to the provisions of the underlying group health plan, an election made to pay the cost of medical coverage for a newborn or newly adopted dependent child pursuant to a HIPAA special enrollment right may be retroactive for up to thirty (30) days, provided it applies to compensation not yet currently available. All other new elections shall be effective prospectively immediately following the date the Participant files the new election with the Plan Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made unless a subsequent event (described above) allows a further election change.

1.8 Who holds the funds I have set aside under the Cafeteria Plan?

Your salary reduction contributions are held as part of the Employer's general assets until they are used to pay for your benefits. There is no separate trust.

1.9 What if I terminate my employment during the Plan Year?

If your employment with the Employer terminates during the Plan Year, your active participation with this Cafeteria Plan ceases and your elections are terminated. You will not be able to make any more contributions under this Cafeteria Plan. You may, however, be entitled to continuation coverage with respect to the underlying benefit plan. See the discussions of continuation coverage later in this summary for additional information.

If you are rehired after thirty (30) days following a termination of employment and again become a Participant, you will have two "periods of coverage" – that period prior to the termination of employment and that period following the re-employment. Expenses incurred prior to the termination of employment shall be subject to the election in effect upon termination. Upon re-employment, you shall have an opportunity to make a new election and expenses incurred after re-employment shall be subject to the election made upon re-employment.

If you are rehired within thirty (30) days following a termination of employment, your election in effect prior to the termination of employment will be reinstated upon re-employment.

1.10 Will I have any administrative costs under the Cafeteria Plan?

No. The entire cost of administering the Cafeteria Plan is paid by the Employer, from Plan forfeitures, or a combination of both.

1.11 How long will the Cafeteria Plan remain in effect?

Although the Employer expects to maintain the Cafeteria Plan (including each of the Optional Benefits) indefinitely, it has the right to amend or terminate the Cafeteria Plan in whole or in part at any time. It is also possible that future changes in state or federal tax laws may require that the Cafeteria Plan be amended or terminated accordingly. You will be informed if any changes are made to the Cafeteria Plan.

1.12 Are my benefits taxable?

Because the Cafeteria Plan is intended to meet certain requirements of the federal tax laws, many of the benefits you receive under the Cafeteria Plan will not be currently taxable to you. However, neither the Employer nor the Plan Administrator can guarantee the tax treatment of benefits with respect to any Participant, as individual circumstances may produce differing results. If you are uncertain, you should consult your own tax adviser.

You should realize that any benefits your receive through the Cafeteria Plan (e.g., premium payments, medical expense reimbursements) cannot be claimed as a medical expense deduction on your income tax return. However, unless your medical expenses exceed seven and one-half percent (7.5%) of your adjusted gross income, you are not permitted to use the deduction anyway.

Any reimbursements made with pre-tax dollars for dependent care expenses affect your ability to claim the dependent care credit. This is explained further in the description of the Dependent Care Flexible Spending Account later in this summary.

Note: If the Plan Administrator determines before or during any Plan Year the Cafeteria Plan may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code, the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a re-characterization within the Plan Year of benefits provided under the Cafeteria Plan as taxable income, with or without consent of the affected Participants.

1.13 What is the impact on my Social Security benefits?

Participating in the Cafeteria Plan will reduce the amount of your taxable compensation. Accordingly, your Social Security benefits, which are based upon your taxable compensation, may be affected at your retirement. However, the tax savings you obtain through participation in the Cafeteria Plan often will offset any reduction in your future Social Security benefits.

1.14 What contributions are made to the Cafeteria Plan?

(a) **Salary Reduction Contributions**. To the extent the cost of an Optional Benefit exceeds the Employer contribution (if any), you may elect in accordance with the election procedures described in Section 1.6 to receive your full compensation in cash, or to have a portion of such compensation applied by the Employer toward your share of the cost of Optional Benefits. If so elected, your compensation will be reduced, and an amount equal to the reduction will be allocated by the Employer to the Optional Benefits you have designated. Your compensation shall be reduced by pro-rata amounts of your total salary

reduction election. Salary reduction is done on a pre-tax basis before any withholdings have been made. The frequency of salary reduction contributions shall be every payroll period. Notwithstanding the forgoing, if participation in an Optional Benefit extends to the last day of the month in which your employment terminates, if necessary, additional salary reduction contributions shall be taken from your final pay check to pay for the coverage provided during the period of time following the date on which your employment terminates.

(c) **Salary Deduction Contributions.** Sometimes the Internal Revenue Code or your Employer does not allow payment with pre-tax dollars. Payments which may be made with after-tax dollars may be paid through a salary deduction agreement. A salary deduction agreement provides for a payroll deduction to be made throughout a Plan Year out of your compensation ***after*** taxes and withholdings have been made.

1.15 What if coverage is provided to someone other than your spouse and tax dependents?

If you participate in an Optional Benefit that covers a dependent who is not your "spouse" or "tax dependent," the entire cost of coverage for Optional Benefits for which you are responsible shall be paid pre-tax through this Cafeteria Plan and the fair market value of the coverage for that Dependent shall be imputed as income to you as the coverage is provided. This provision applies regardless of whether the cost of coverage is paid by salary reduction or allocation of available Employer contributions, if any.

For purposes of this Cafeteria Plan, **"spouse"** means a person to whom you are legally married in accordance with applicable state law.

For purposes of this Cafeteria Plan, **"tax dependent"** generally includes an individual who satisfies the requirements of paragraph (a), (b), or (c) below:

(a) an individual who:

(1) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption); and

(2) will not attain age 27 during the relevant calendar year.

(b) An individual who:

(1) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;

(2) has the same principal place of abode as you for at least one-half of the relevant year;

(3) will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled;

(4) did not provide over half of his/her own support during the relevant year;

(5) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;

(6) is younger than you (unless he/she is permanently and totally disabled); and

(7) does not file a joint tax return with his or her spouse.

(c) An individual who:

(1) is your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent's ancestor), stepparent, brother or sister's son or daughter, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household;

(2) has received more than one-half of his/her support from you during the relevant year;

(3) is not your qualifying child or the qualifying child of anyone else (i.e., does not satisfy the requirements of paragraph (a) above with respect to any person); and

(4) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

NOTE: The definition "tax dependent" is different than the definition applicable under the Internal Revenue Code for purposes of identifying who you may claim as an exemption on your federal income tax return and is different than the definition of "qualifying individual" that applies under the Dependent Care Flexible Spending Account. Additional special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

1.16 How are claims determined?

NOTE: This claims determination procedure applies only with respect to issues related to the Cafeteria Plan (e.g., the ability to pay for benefits on a pre-tax basis and the election of Optional Benefits) and claims for reimbursement under the Group Medical Plan, Group Dental Plan, Group Term Life and AD&D Plan, Flexible Spending Account, Limited Scope Flexible Spending Account, Dependent Care Flexible Spending Account and HSA Contribution Feature. Claims for other benefits (e.g., claims under the major medical and dental coverages are handled through the claims determination procedures in those separate plans or policies.

(a) **Claim Submission**. Unless a separate procedure is provided with respect to an Optional Benefit, a claim for benefits must be made in writing and submitted to the Claims Administrator. Please refer to the sections of this summary describing each Optional Benefit for additional information.

(b) **Benefits Denials**. The Claims Administrator will decide your claim within a reasonable time not longer than thirty (30) days after it is received. This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Claims Administrator, including when a claim is incomplete. You will receive written notice of any extension, indicating the reasons for the extension and the date by which a decision is expected to be made. If your claim is incomplete, and the Claims Administrator notifies you of that fact, the time period for deciding your claim will be suspended from the date the notice is provided through the date on which you respond or by which you are supposed to respond. You will be given at least forty-five (45) days in which to respond. The Claims Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your claim.

If the Claims Administrator denies your claim, in whole or in part, you will be furnished with a written notice of adverse benefit determination setting forth:

(1) the specific reason or reasons for the denial;

(2) reference to the specific Plan provision on which the denial is based;

(3) a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and

(4) appropriate information as to the steps to be taken if you wish to appeal the Claims Administrator's determination, including your right to submit written comments and have them considered, and your right to review (on request and at no charge) relevant documents and other information.

(c) **Appealing a Denial**. If your claim is denied in whole or in part, you may appeal to the Plan Administrator for a review of the denied claim. Your appeal must be made in writing within one hundred eighty (180) days of the Plan Administrator's initial notice of adverse benefit determination or you will lose your right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

(d) **Decision upon Appeal**. The Plan Administrator will review and decide your appeal within a reasonable time not longer than sixty (60) days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. (The identity of a medical expert consulted in connection with your appeal will be provided.) If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

(1) the specific reason(s) for the denial;

(2) the specific Plan provision(s) on which the decision is based;

(3) a statement of your right to review (on request and at no charge) relevant documents and other information;

(4) if the Plan Administrator relied on "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.

1.17 How are insurance refunds handled?

Any refund provided to the Employer by an insurance company that has issued an insurance contract for a component of the Cafeteria Plan will be allocated as provided herein. The refund will constitute Plan assets only to the extent required by applicable law.

1.18 Who has authority to interpret the Plan?

To the fullest extent permitted under applicable law, the Plan Administrator and any other Plan fiduciary acting in its fiduciary capacity shall have the authority and discretion to interpret and apply Plan terms.

PART II.
GROUP MEDICAL BENEFITS

2.1 What benefits are provided?

An important feature of the Cafeteria Plan is the opportunity it provides you to pay your share of the cost of medical coverage on a pre-tax basis. The medical coverage is provided through your Employer and is referred to herein as the "Group Medical Plan." Your share of the cost for that coverage is paid with the allocation of Employer contributions (if any) and pre-tax dollars through salary reduction under this portion of the Cafeteria Plan.

The Group Medical Plan is described in separate materials which have been provided to you either directly by the carrier (the insurance company or HMO) or by your Employer. Those descriptive materials are incorporated into this summary description by reference. If you have not been provided this information, you should contact the Plan Administrator. The benefits under the Group Medical Plan are provided in accordance with the applicable Group Medical Plan documents.

The Group Medical Plan is subject to privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

2.2 How do I become a Participant in this portion of the Cafeteria Plan?

To participate in this portion of the Cafeteria Plan, you must first enroll in the Group Medical Plan. You may select coverage under the Group Medical Plan for just yourself, or you may select coverage for yourself and others who are eligible for coverage under the terms of the Group Medical Plan. Please refer to the contract or policy governing the Group Medical Plan for information regarding who is eligible for coverage under that plan and how to enroll in that plan.

If you have enrolled in the Group Medical Plan, then you may participate in this portion of the Cafeteria Plan if you satisfy the general eligibility requirements for the Cafeteria Plan described in Section 1.4. If you satisfy those requirements, you will automatically become a Participant in this portion of the Cafeteria Plan for purposes of paying your share of the cost of Group Medical Plan coverage unless you elect not to do so.

2.3 How is my cost of group medical coverage paid?

If you participate in this portion of the Cafeteria Plan, your cost of coverage under the Group Medical Plan is generally paid by allocation of pre-tax dollars through salary reduction.

NOTE: You must be a Participant in the Cafeteria Plan for your portion of the premiums to be paid pre-tax.

If you pay the cost of Group Medical Plan coverage through this portion of the Cafeteria Plan and you have enrolled an individual who is not your spouse or "tax dependent" (as those terms are defined in Section 1.16), then the taxation of that individual's coverage will be handled as described in Section 1.16.

2.4 What if I am no longer eligible?

If you cease to be eligible for coverage under the Group Medical Plan, your coverage under that Plan will terminate in accordance with the terms and conditions of that Plan. In most cases, if you lose coverage under the Group Medical Plan, your participation in this portion of the Cafeteria Plan will cease as well, subject to the change in election rules described in Section 1.8.

If you cease to be eligible to participate in this Cafeteria Plan, your ability to pay for coverage under the Group Medical Plan on a pre-tax basis through this portion of the Cafeteria Plan stops.

2.5 Can coverage be continued?

If you cease to be eligible for coverage under the Group Medical Plan, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). These continuation rights are described later in this summary.

2.6 What if I am subject to a medical child support order?

The Group Medical Plan recognizes child support orders regarding the provision of medical coverage for a child, including orders under the Child Support Performance and Incentive Act of 1998 to the extent required by law. If a child is enrolled in the Group Medical Plan pursuant to a child support order, you will be able to pay the cost of that coverage through this portion of the Cafeteria Plan, provided you are eligible to participate as described above.

PART III.
GROUP DENTAL BENEFITS

3.1 What benefits are provided?

An important feature of the Cafeteria Plan is the opportunity it provides to pay your share of the cost of dental coverage on a pre-tax basis. The dental coverage is provided through your Employer and is referred to herein as the "Group Dental Plan." Your share of the cost for that coverage is paid with the allocation of pre-tax dollars through salary reduction under this portion of the Cafeteria Plan.

The Group Dental Plan is described in separate materials which have been provided to you either directly by the carrier (the insurance company or DMO) or by your Employer. Those descriptive materials are incorporated into this summary description by reference. If you have not been provided this information, you should contact the Plan Administrator. The benefits under the Group Dental Plan are provided in accordance with the applicable Group Dental Plan documents.

The Group Dental Plan is subject to the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

3.2 How do I become a Participant?

To participate in this portion of the Cafeteria Plan, you must first enroll in the Group Dental Plan. You may select coverage under the Group Dental Plan for just yourself, or you may select coverage for yourself and others who are eligible for coverage under the terms of the Group Dental Plan. Please refer to the contract or policy governing the Group Dental Plan for information regarding who is eligible for coverage under that plan and how to enroll in that plan.

If you have enrolled in the Group Dental Plan, then you may participate in this portion of the Cafeteria Plan if you satisfy the general eligibility requirements for the Cafeteria Plan described in Section 1.4. If you satisfy those requirements, you will automatically become a Participant in this portion of the Cafeteria Plan for purposes of paying your share of the cost of Group Dental Plan coverage unless you elect not to do so.

3.3 How is my cost of group dental coverage paid?

If you participate in this portion of the Cafeteria Plan, your cost of coverage under the Group Dental Plan is generally paid by allocation of pre-tax dollars through salary reduction.

NOTE: You must be a Participant in the Cafeteria Plan for your portion of the premiums to be paid pre-tax.

If you pay the cost of Group Dental Plan coverage through this portion of the Cafeteria Plan and you have enrolled an individual who is not your spouse or "tax dependent" (as those terms are defined in Section 1.16), then the taxation of that individual's coverage will be handled as described in Section 1.16.

3.4 What if I am no longer eligible?

If you cease to be eligible for coverage under the Group Dental Plan, your coverage under that Plan will terminate in accordance with the terms and conditions of that Plan. In most cases, if you lose coverage under the Group Dental Plan, your participation in this portion of the Cafeteria Plan will cease as well, subject to the change in election rules described in Section 1.8.

If you cease to be eligible to participate in this Cafeteria Plan, your ability to pay for coverage under the Group Dental Plan on a pre-tax basis through this portion of the Cafeteria Plan stops.

3.5 Can coverage be continued?

If you cease to be eligible for coverage under the Group Dental Plan, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"),. These continuation rights are described later in this summary.

3.6 What if I am subject to a medical child support order?

The Group Dental Plan recognizes child support orders regarding the provision of medical coverage for a child, including orders under the Child Support Performance and Incentive Act of 1998 to the extent required by law. If a child is enrolled in the Group Dental Plan pursuant to a child support order, you will be able to pay the cost of that coverage through this portion of the Cafeteria Plan, provided you are eligible to participate as described above.

PART IV.
GROUP TERM LIFE AND AD&D BENEFITS

4.1 What benefits are provided?

An important feature of the Cafeteria Plan is the opportunity it provides you to pay your share of the cost of group term life insurance and/or accidental death and dismemberment insurance coverage on a pre-tax basis. The coverage is provided through your Employer and is referred to as the "Group Term Life and AD&D Plan". Your share of the cost for that coverage is paid with the allocation of pre-tax dollars through salary reduction under this portion the Cafeteria Plan.

NOTE: The Plan does not allow the pre-tax payment of the cost of your spouse or dependent's life insurance coverage.

The Group Term Life and AD&D Plan is fully insured, which means that all benefits are provided through one or more contracts or policies obtained by your Employer with one or more third party insurance carriers. The Group Term Life and AD&D Plan is described in separate materials which have been provided to you either directly by the insurance carrier or by the Employer. Those descriptive materials are incorporated into this summary description by reference. If you have not been provided this information, you should contact the Plan Administrator. The group term life and accidental death and dismemberment benefits are provided in accordance with the applicable contract or policy issued by the carrier.

4.2 How do I become a Participant in this portion of the Cafeteria Plan?

To participate in this portion of the Cafeteria Plan, you must first enroll in the Group Term Life and AD&D Plan. Please refer to the contract or policy governing the Group Term Life and AD&D Plan for information regarding how to enroll in that plan.

If you have enrolled in the Group Term Life and AD&D Plan, then you may participate in this portion of the Cafeteria Plan if you satisfy the general eligibility requirements for the Cafeteria Plan described in Section 1.4. If you satisfy those requirements, [you will automatically become a Participant in this portion of the Cafeteria Plan for purposes of paying your share of the cost of Group Term Life and AD&D Plan coverage unless you elect not to do so.

4.3 How is my cost of coverage paid?

If you participate in this portion of the Cafeteria Plan, your cost of coverage under the Group Term Life and AD&D Plan is paid by allocation of pre-tax dollars through salary reduction. Your Employer will forward the salary reduction dollars (if any) to the insurance carrier along with any Employer contribution you have designated to be used to pay for this coverage.

NOTE: You must be a Participant in the Cafeteria Plan for your portion of the premiums to be paid pre-tax.

4.4 How much group term life insurance coverage can I purchase?

Up to $50,000 worth of Employer paid coverage may be excluded from your taxable income. For this purpose, "Employer paid" includes coverage automatically provided by the Employer, and coverage paid by you on a pre-tax basis through salary reduction under this Cafeteria Plan. If the face amount of the Employer paid coverage exceeds $50,000, the cost of the coverage in excess of $50,000 will be imputed to you as income to the extent required by law.

4.5 What if I am no longer eligible?

If you cease to be eligible for coverage under the Group Term Life and AD&D Plan, your coverage under that plan will terminate in accordance with the terms and conditions of that plan. In most cases, if you lose coverage under the Group Term Life and AD&D Plan, your participation in this portion of the Cafeteria Plan will cease as well, subject to the change in election rules described in Section 1.8.

If you cease to be eligible to participate in this Cafeteria Plan, your ability to pay for coverage under the Group Term Life and AD&D Plan on a pre-tax basis through this portion of the Cafeteria Plan stops.

4.6 Can coverage be continued?

If you cease to be eligible for coverage under the Group Term Life and AD&D Plan, you ***may*** be able to continue that coverage. There shall be compliance with applicable state law regarding continuation of coverage and conversion of coverage to the extent such state law is not preempted by federal law. In addition, any continuation and conversion rights provided under the terms of the insurance contract(s) through which benefit are provided shall be available to the extent they are not prohibited or preempted by federal law.

PART V.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

5.1 What benefits are provided?

The Plan permits you to elect to receive reimbursement for some or all of your work related dependent care expenses under the Dependent Care Flexible Spending Account ("Dependent Care FSA"). Under the Dependent Care FSA, you provide a source of pre-tax dollars by entering into a salary reduction arrangement with your Employer. Those pre-tax dollars will be used to reimburse you for your eligible expenses. You save Social Security and income taxes on the amount of your salary reduction for dependent care expenses.

NOTE: Participation in the Dependent Care FSA will impact your ability to receive the dependent care tax credit with respect to your federal income taxes. Additional information is provided below regarding this tax credit.

5.2 How do I become a Participant in the Dependent Care FSA?

To become a Participant in the Dependent Care FSA, you must first become a Participant in the Cafeteria Plan. You must also satisfy the eligibility requirements for the Dependent Care FSA. The Dependent Care FSA's eligibility requirements are the same as the eligibility requirements for the Cafeteria Plan as described in Section 1.4. If you satisfy those requirements, you become a Participant in the Dependent Care FSA by electing benefits under the Dependent Care FSA during your initial or subsequent annual enrollment periods.

5.3 What is my account?

If you elect benefits under the Dependent Care FSA, an account will be established in your name to keep a record of the benefits to which you are entitled. When you complete the election form, you specify the amount of benefits you wish to receive. These benefits may be funded by allocation of with

pre-tax dollars through salary reduction contributions. A pro-rated portion of your election will be credited to your account according to the schedule described in Section 1.14.

The amount that is available in your account at any particular time will be whatever has been credited to such account less any reimbursements.

The account is a bookkeeping account only. The Employer pays benefits under the Dependent Care FSA from its general assets. There is no trust.

5.4 What are the maximum benefits I may receive?

The maximum amount of benefits you may receive under the Dependent Care FSA is $5,000 per calendar year if you:

(a) are married and file a joint return;

(b) are married, but you furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA, your spouse maintains a separate residence for the last six (6) months of the calendar year, and you file a separate tax return; or

(c) are single, or a head of household for tax purposes.

This maximum is reduced if any of the following situations exist:

(a) if you are married and reside together with your spouse, but file separate tax returns, the maximum is reduced to $2,500 (and only one parent may submit claims for reimbursement under the Dependent Care FSA); or

(b) if you or your spouse have earned income less than $5,000 per tax year, the maximum is reduced to the lesser of your earned income or your spouse's earned income.

Note: The Dependent Care FSA Plan's maximum described above is also the maximum amount of employer-provided dependent care benefits that are excludable from income. If you are married, the maximum tax exclusion applies on a combined or aggregate basis. Accordingly, if your spouse has a dependent care program available through his or her employer, the maximum annual tax exclusion will apply to the combined benefits received by your spouse under his/her employer's program plus the benefits you receive under this Dependent Care FSA Plan. ***It is your responsibility to monitor your combined maximum benefits and to report any benefits in excess of the maximum on your income tax return.***

NOTE: If your spouse is a student or is incapable of caring for himself or herself, in general, you spouse will be deemed to have earned income of not less than $250 per month if you have one Qualifying Individual or $500 per month you have two or more Qualifying Individuals.

5.5 Who is a "Qualifying Individual" for whom I can submit claims for reimbursement?

NOTE: The rules are not the same as the tax deduction or exemption rules. It is your responsibility to determine whether you can request reimbursement for expenses incurred with respect to a particular individual. As discussed below, special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

General Rule. Subject to the two special rules described below, you may be reimbursed for Eligible Expenses incurred with respect to any "Qualifying Individual." A Qualifying Individual is a person described in paragraph (a), (b), (c), (d) or (e) below.

(a) Your "child" who:

(1) is under age thirteen (13);

(2) has the same principal place of abode as you for at least one-half of the year;

(3) does not provide over half of his/her own support during the year; and

(4) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico

(b) Your "child" who:

(1) is mentally or physically unable to care for himself or herself;

(2) has the same principal place of abode as you for at least one-half of the year;

(3) does not provide over half of his/her own support during the year;

(4) has not attained age nineteen (19) during the year (age twenty-four (24) if a full-time student) or is permanently and totally disabled;

(5) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;

(6) is younger than you (unless he/she is permanently and totally disabled); and

(7) does not file a joint tax return with his or her spouse.

(c) Your "child" who:

(1) is mentally or physically unable to care for himself or herself,

(2) has the same principal place of abode as you for at least one-half of the year,

(3) has received more than one-half of his/her support from you during the relevant year,

(4) is not any person's "qualifying child" (as that term is defined under Section 152 of the Code), and

(5) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

(d) Your "relative" who:

(1) is mentally or physically unable to care for himself or herself,

(2) has the same principal place of abode as you for at least one-half of the year,

(3) has received more than one-half of his/her support from you during the relevant year,

(4) is not any person's "qualifying child" (as that term is defined under Section 152 of the Code), and

(5) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

(e) Your "spouse," if your spouse is physically or mentally incapacitated and has the same principal place of abode as you for at least one-half of the year.

"*Child*" generally includes your son, daughter, stepson, stepdaughter, eligible foster child, brother, sister, stepbrother, stepsister, or a descendant of any such person.

"*Relative*" generally includes parent (or a parent's ancestor), stepparent, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or an individual who (although not related to you) has the same principal place of abode as you and is a member of your household.

"*Spouse*" means an individual to whom you are legally married under applicable state law.

5.6 What if two people claim a child as a Qualifying Individual?

With the exception of two parents that file income taxes jointly, only one person is entitled to treat the child as a Qualifying Individual. Where multiple people are involved, there are two special rules to determine which person is entitled to treat the child as a Qualifying Individual.

(a) **Divorced or Separated Parents, or Parents Living Apart**.

Important Note: In this situation, only one person is entitled to treat the child as a Qualified Individual for purposes of the Dependent Care FSA.

If a child's parents are divorced, legally separated, separated pursuant to a written agreement, or live apart at all times during the last six (6) months of the calendar year, a special rule applies if: (i) the child is under age 13 or is mentally or physically unable to care for himself or herself; (ii) the child receives more than 50% of his or her support from the parents (in aggregate); and (iii) the child resides with the parents (in aggregate) for more than 50% of the year. In such situations, the child is the Qualifying Individual of the custodial parent even if the custodial parent has released the right to claim the child as a dependent. The custodial parent is generally the parent with whom the child resides for the greater number of nights during the calendar year or, if the child resides with both parents for an equal number of nights, the parent with the higher adjusted gross income for the year.

(b) **Other Situations**. If the special rule described above regarding divorce, etc. does not apply, other special tie-breaker rules of may apply. If an individual is a Qualifying Individual (under paragraphs (a) or (b) of the definition provided above) with respect to more than one person, then:

(1) if both persons are the individual's parents and they file separate federal income tax returns, then the child is the Qualifying Individual of the parent with whom the child resides for the longest period of time during the calendar year (or, if child resides with both parents for the same amount of time during the year, the parent with the highest adjusted gross income for the year). However, if that parent (i.e., the custodial parent or the parent with the highest adjusted gross income) does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other parent (i.e., the non-custodial parent or the parent with the lowest adjusted gross income). *This is the one person that is entitled to treat the child as a Qualifying Individual for purposes of the Dependent Care FSA*.

(2) if one person is the individual's parent and the other is not, the child is the Qualifying Individual of the parent. However, if the parent does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other person (i.e., the non-parent). *This is the one person that is entitled to treat the child as a Qualifying Individual for purposes of the Dependent Care FSA.*

(3) if neither person is the individual's parent, the child is the Qualifying Individual of the person with the highest adjusted gross income for the year in question. However, if that person does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the Earned Income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other person (i.e., the person with the lowest adjusted gross income). *This is the one person that is entitled to treat the child as a Qualifying Individual for purposes of the Dependent Care FSA*.

Important: If you enroll for dependent care benefits, it will be assumed that you are *the one person* entitled to treat the child as a Qualifying Individual for purposes of reimbursement under the Dependent Care FSA.

5.7 What is an "Eligible Expense"?

(a) **General Rule—Covered**. An "Eligible Expense" generally means expenses for the care of a Qualifying Individual incurred by you (or your spouse) to enable you (and your spouse) to be gainfully employed. Eligible Expenses generally include:

(1) day care expenses;

(2) the cost of nursery school, preschool, or similar programs below the level of kindergarten;

(3) the cost of after-school care (including care for Qualifying Individuals in kindergarten and beyond);

(4) the cost of day camp, including specialty day camp (but *not* overnight camp);

(5) the cost of transportation provided by a care provider;

(6) the cost of meals incidental to and inseparable from care;

(7) employment taxes paid on behalf of a care provider;

(8) the cost of room and board provided to a care provider (e.g., a live in nanny);

(9) certain indirect expenses, such as application and agency fees, if they must be paid to obtain the care and care is actually provided; and

(10) placement or "hold the spot" fees provided that they must be paid to obtain the care (not Eligible Expenses unless and until care is actually provided by the provider to whom such fees are paid).

(b) **General Rule—Not Covered**. Expenses incurred that do not enable you to be gainfully employed are generally not "eligible" including, but not limited to, expenses incurred while on vacation, sick leave, or any other type of situation where you (and your spouse) are not at work or actively looking for work (i.e., gainfully employed). Your spouse, if any, is deemed to be gainfully employed if he/she is: (1) a full time student, or (2) mentally or physically incapable of self-care and resides with you for more than one-half of the calendar year.

(c) **Daily Allocation**. Usually, expenses must be allocated on a daily basis so that expenses incurred on a day you (or your spouse) were not at work may not be reimbursed.

Special Rule. If you pay for care on at least a weekly basis, without deduction for days on which care is not provided, you are not required to allocate expenses for short, temporary absences from work, such as vacations and sick days. You are also not required to allocate expenses on a daily basis if you (or your spouse) work on a part-time basis and you pay for care on at least a weekly basis without deduction for days on which care is not provided.

(d) **Who and Where Rules**. Expenses that would otherwise be "Eligible Expenses" cannot be reimbursed if they are paid to: (1) an individual who is your child under the age of nineteen (19) at the end of the calendar year; (2) an individual you (or your spouse) claim as a dependent on your tax return; (3) an individual who was your spouse at any time during the calendar year; or (4) a parent of a Qualifying Individual who is your child under age thirteen (13).

Expenses that would otherwise be "Eligible Expenses" for services provided outside of your home may be reimbursed only if the care is for a Qualifying Individual who is: (1) your (or your spouse's) "child" under the age of thirteen (13); or (2) is another Qualifying Individual who regularly spends at least eight (8) hours per day in your home.

5.8 How do I receive reimbursements under the Dependent Care FSA?

(a) **Periodic Reimbursements.** When you incur an expense that is eligible for reimbursement, you submit a claim to the Claims Administrator on a claim form that will be supplied to you. The claim form may be submitted via email, facsimile, mail, or the Claims Administrator's website. The claim form will typically set forth:

(1) the amount, date and nature of the expense;

(2) the name of the person or entity to which the expense was paid;

(3) your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source; and

(4) such other information as the Plan Administrator may require. You may also be required to submit copies of bills or receipts from the provider(s) to support your claim.

If there are enough dollars credited to your account, you will be reimbursed for your Eligible Expenses according to the schedule established by the Plan Administrator.

Claim Deadline. You may submit claims for reimbursement of Eligible Expenses incurred during the Plan Year for 90 days following the end of that Plan Year. This period following the end of the Plan Year during which claims for reimbursement may be filed is referred to as the "claims run-out period."

(b) **Electronic Payment Card.** The electronic payment card allows you to pay for Eligible Expenses at the time that you incur the expense. The electronic payment card works as follows:

(1) **You must make an election to use the card**. In order to be eligible for the electronic payment card, you must agree to abide by the terms and conditions of the electronic payment card program as set forth herein and in the electronic payment cardholder agreement (the "Cardholder Agreement"), including agreeing to any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset ineligible claims, etc. You must agree to abide by the terms of the program each Plan Year. A Cardholder Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the program for the new Plan Year. The Cardholder Agreement is part of the terms and conditions of your Plan and this summary.

(2) **The balance of the card is limited**. The balance of the card is limited to the balance of your account.

(3) **The card will be turned off when employment or coverage terminates**. The card will be turned off when you terminate employment or coverage under the Plan.

(4) **You must certify proper use of the card**. As specified in the Cardholder Agreement, you certify during the applicable Plan Year that the amounts in your account will only be used for Eligible Expenses and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(5) **Expenses must be substantiated.** To ensure that expenses for which the card is used are Eligible Expenses, the following procedures must be followed:

(A) At the beginning of each Plan Year or, if later, upon beginning participation, you must pay the initial Eligible Expense to the dependent

care provider and submit a paper claim to the Plan (as described above) for such expense.

(B) Upon substantiation by the Claims Administrator of the initial Eligible Expense, the Plan will make available through the electronic payment card an amount equal to the lesser of: (i) the amount of the approved claim, or (ii) the balance of your account as of that date.

(C) The electronic payment card may then be used to pay for subsequently incurred Eligible Expenses.

(D) The amount available through the electronic payment card may be increased only as additional dependent care expenses are incurred and substantiated via submission of a paper claim, except as provided in paragraph (E) below. In no case will the amount available through the electronic payment card exceed the contributions to your account for the Plan Year to date minus the amount of expenses previously reimbursed during such Plan Year (whether such reimbursement was made in cash or by crediting the electronic payment card).

(E) Dependent care expenses may be automatically substantiated without submission of a paper claim only as provided in this paragraph (E). If (i) an electronic payment card transaction collects information that matches information for a previously approved paper claim with respect to the dependent care provider, and (ii) the amount of the electronic payment card transaction is equal to or less than the previously approved paper claim, then the claim paid via the electronic payment card is substantiated without further review. In such instances, the balance of the electronic payment card may be increased with respect to the automatically substantiated claim once the expense paid through the electronic payment card has been incurred.

Example: If you use an electronic payment card to pay a day care provider on the first day of the week for the care to be provided during that week, and the claim is automatically substantiated as provided above, the balance of the electronic payment card may be increased with respect to such claim at the end of the week.

5.9 What limits apply to reimbursements under the Dependent Care FSA?

You cannot be reimbursed for any expenses above your ***available*** account balance. If your claim was for an amount that was more than your current account balance, the excess part of the claim will be carried over into following months, to be paid as your balance becomes adequate. You also cannot be reimbursed for any expenses that arise before the effective date of the Dependent Care FSA, for any expenses that arise before you become a Participant in the Dependent Care FSA, or for any expenses incurred after the close of the Plan Year.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

5.10 What is the Grace Period?

"Grace Period" means the period beginning on January 1 and ending on March 15 each Plan Year. Claims incurred during the Grace Period will be considered to have been incurred during both the preceding Plan Year and the current Plan Year. For example, a claim incurred on March 1, 2018 will be deemed to have been incurred during both the Plan Year running from January 1 through December 31, 2017, and the Plan Year running from January 1 through December 31, 2018.

Claims incurred during the Grace Period will be first allocated to and reimbursed from your account for the preceding Plan Year until such account is exhausted. Thereafter, any such claims will be allocated to and reimbursed from your account for the current Plan Year. Claims incurred during the Grace Period will be allocated based upon the date the claim is received. Once a claim is allocated to an account, no changes, modifications, or adjustments will be allowed. In addition, no adjustment to your election for the current Plan Year may be made based upon the amount of claims incurred during the Grace Period that are reimbursed from the prior Plan Year's account.

NOTE: A claim incurred during the preceding Plan Year and submitted during the claims run-out period described above will be processed subsequent to a previously submitted claim incurred during the Grace Period, even if your account from the preceding Plan Year is exhausted by reimbursement of the claim incurred during the Grace Period.

5.11 Will I be taxed on the Dependent Care FSA benefits I receive?

You will not normally be taxed on benefits under the Dependent Care FSA. However to qualify for tax-free treatment, you will be required to file IRS Form 2441 or a similar form with a list of names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you claimed a tax-free reimbursement.

CAUTION: Eligible Expenses incurred and reimbursed during the Grace Period must be reported on Form 2441 for the year including the Grace Period. As a result, if you elect the maximum benefit for a particular year and receive benefits during the Grace Period applicable to the prior year, you may receive excess benefits. For example, if you have $1,000 of benefits left from the 2018 Plan Year that are used during the Grace Period applicable to that year, and elect and receive an additional $5,000 in benefits during 2019, you will have exceeded the $5,000 maximum applicable during 2019.

5.12 If I participate in the Dependent Care FSA, will I still be able to claim the household and dependent care tax credit on my federal income tax return?

You may choose to participate in the Dependent Care FSA and receive credit on your federal income tax return too. However, the tax credit and the account cannot be used for the same expenses. In addition, the amount of the household and dependent care tax credit is reduced dollar for dollar by the reimbursement you receive from your account.

In certain cases, it may be more beneficial for you to claim a tax credit for your dependent care expenses rather than pay for those expenses through the account. You may want to consult your tax advisor regarding the best options under the applicable rules.

5.13 What is the dependent care tax credit?

The dependent care tax credit is an allowance for a percentage of your annual eligible dependent care expenses as a credit against your federal income tax. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one dependent, or $6,000 for two or more dependents.

Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one dependent or $2,100 for two or more dependents) to a minimum of 20% of such expenses (producing a maximum credit of $600 for one dependent or $1,200 for two or more dependents.) The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross incomes over $15,000.

5.14 When would it be better for me to use the tax credit?

In general, if your income tax bracket is 15% or less, it will be more advantageous for you to forego participation in the Dependent Care FSA, pay the expenses with after-tax dollars, and claim the dependent care tax credits. However, you should analyze your own situation carefully to determine which method is right for you. The actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of dependents, etc. Each Participant will have to determine his or her tax position individually in order to make the decisions between taxable and tax-free benefits. If you are uncertain about whether to participate in this Dependent Care FSA or take the dependent care credit, you should consult your tax advisor.

Please refer to Exhibit B for an example of how choosing between participating in the Dependent Care FSA and taking the household and dependent care tax credit will impact your disposable income.

5.15 What if I am no longer eligible?

If your employment terminates or you otherwise cease to be eligible for coverage under the Dependent Care FSA, you may not make any further contributions to your account. However, you may continue to submit claims for reimbursement of Eligible Expenses incurred both while you were a Participant and during the remainder of the Grace Period in which your participation ceased until the expiration of the claims run out period.

If your employment terminates or you otherwise cease to be eligible for coverage under the Dependent Care FSA, you may not make any further contributions to your account. However, you may continue to submit claims for reimbursement of Eligible Expenses incurred while you were a Participant until the expiration of the claims run out period.

If your employment terminates or you otherwise cease to be eligible for coverage under the Dependent Care FSA, you may not make any further contributions to your account. However, you may continue to submit claims for reimbursement of Eligible Expenses incurred while you were a Participant for a period of ninety (90) days after the date you ceased to be eligible to participate.

5.16 What if I receive benefits in error?

If a reimbursement is made by the Dependent Care FSA in excess of the amount to which you are entitled under the Dependent Care FSA, the Dependent Care FSA has the right to recover such overpayment. Repayment of an overpayment is a condition of participation in the Cafeteria Plan.

5.17 What if the dependent care expenses I incur during the Plan Year are less than the annual benefit I have elected?

Any amounts remaining in your account attributable to a particular Plan Year shall be forfeited following the claims run-out period described in Section 3.6. You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual dependent care

expenses you have incurred, on the one hand, and the annual benefit you have elected and paid for, on the other. *If you do not use it, you lose it.*

5.18 What reporting will I receive?

The amounts reimbursed under this Dependent Care FSA for each calendar year will be reported on your W-2. If the actual amount paid is not known by the deadline for providing the W-2 (e.g., because of the claims run-out period), the Employer may report a reasonable estimate of the reimbursements that will be paid under the Dependent Care FSA for the year. A reasonable estimate may be the amount of benefits you elected under the Dependent Care FSA for the year.

5.19 Is the Dependent Care FSA Plan governed by ERISA?

No. The Dependent Care FSA Plan is not subject to ERISA. Part VIII of this summary does not apply to the Dependent Care FSA Plan.

5.20 Is the Dependent Care FSA Plan subject to COBRA?

No. The Dependent Care FSA Plan is not subject to COBRA.

5.21 Is the Dependent Care FSA Plan subject to HIPAA?

No. The Dependent Care FSA Plan is not a group health plan, and, therefore, not subject to HIPAA Privacy, HIPAA Security, or HIPAA Special Enrollment.

PART VI.
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 What benefits are provided?

The Plan permits you to elect to receive reimbursement for some or all of your uninsured medical and dental expenses under the Health Flexible Spending Account ("Health FSA"). Under the Health FSA, you provide a source of pre-tax dollars by entering into a salary reduction agreement with your Employer.. Those pre-tax dollars will be used to reimburse you for your Eligible Expenses. You save Social Security and income taxes on the amount of your salary reduction for medical expenses.

The coverage provided through the Health FSA is subject to the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Health FSA is intended to be an excepted benefit under the HIPAA portability rules. Accordingly, neither the HIPAA portability rules nor the mandates of the Patient Protection and Affordable Care Act, as amended, including the preventive care mandate, apply to the Health FSA.

6.2 How do I become a Participant?

To become a Participant in the Health FSA, you must first become a Participant in the Cafeteria Plan. You must also satisfy the eligibility requirements for the Health FSA. The Health FSA's eligibility requirements are the same as the eligibility requirements for the Cafeteria Plan as described in Section 1.4. If you satisfy those requirements, you become a Participant in the Health FSA by electing benefits under the Health FSA during your initial or subsequent annual enrollment periods.

NOTE: Participation in this Health FSA will make you ineligible to participate in the HSA Contribution Feature, and will make you and any of your dependents covered by the Health FSA ineligible to make or receive contributions to a health savings account.

6.3 What is my account?

If you elect benefits under the Health FSA, an account will be established in your name to keep a record of the benefits to which you are entitled. When you complete the election form, you specify the amount of benefits you wish to receive. These benefits may be funded by allocation pre-tax dollars through salary reduction contributions.

The full amount of your election under the Health FSA will be available at any time during the Plan Year, reduced by the amount of prior reimbursements under the Health FSA received during the Plan Year.

The account is a bookkeeping account only. Benefits under the Health FSA are paid from the Employer's general assets. There is no trust.

6.4 What are the maximum reimbursements I may receive?

The maximum amount of medical expense reimbursements is IRS Maximum as defined at time of open enrollment per Plan Year. For a short Plan Year, the maximum is unchanged for the number of pay periods remaining in the Plan Year. If you enter the plan mid-year, this maximum amount will be unchanged for the number of pay periods remaining in the Plan Year.

6.5 What is an "Eligible Expense"?

(a) **Generally**. An "Eligible Expense," in most situations, means any item for which you could have claimed a medical expense deduction on an itemized federal income tax return and for which you have not otherwise been reimbursed from health coverage, or some other source. Eligible Expenses include expenses incurred by you and your "spouse" and "dependents."

For purposes of this Health FSA, **"spouse"** means a person to whom you are legally married in accordance with applicable state law.

For purposes of this Health FSA, **"dependent"** generally includes an individual who satisfies the requirements of paragraph (1), (2), or (3) below:

(1) An individual who:

(i) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption); and

(ii) will not attain age 27 during the relevant calendar year.

(2) An individual who:

(i) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;

(ii) has the same principal place of abode as you for at least one-half of the relevant year;

(iii) will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled;

(iv) did not provide over half of his/her own support during the relevant year;

(v) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;

(vi) is younger than you (unless he/she is permanently and totally disabled); and

(vii) does not file a joint tax return with his or her spouse.

(3) An individual who:

(i) is your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent's ancestor), stepparent, brother or sister's son or daughter, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household;

(ii) has received more than one-half of his/her support from you during the relevant year;

(iii) is not your qualifying child or the qualifying child of anyone else (i.e., does not satisfy the requirements of paragraph (1) above with respect to any person); and

(iv) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

NOTE: The definition "dependent" is different than the definition applicable under the Internal Revenue Code for purposes of identifying who you may claim as an exemption on your federal income tax return. Furthermore, an individual eligible for dependent coverage under the Group Medical Plan is not necessarily a "dependent" for purposes of the Health FSA. Additional special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

(b) **Special rules for over-the-counter items.** Eligible Expense ***includes*** certain over-the-counter items that constitute medical care (under Section 213(d) of the Internal Revenue Code) even though a tax deduction is not available. Over-the-counter drugs and medicines (other than insulin) require a prescription to be an Eligible Expense. For this purpose, a "prescription" means a written or electronic order for a medicine or drug (1) that meets the legal requirements of a prescription in the state in which the medical expense is incurred, and (2) that is issued by an individual who is legally authorized to issue a prescription in that state.

(c) **Exceptions**. Despite the general rule stated above, Eligible Expense ***does not*** include premiums for qualified long term care coverage or premiums for any group or individual health plan.

IMPORTANT: Please review Exhibit A—Eligible Medical Care Expenses to help determine what is an Eligible Expense. You are also encouraged to consult your personal tax advisor or IRS Publication 502, "Medical and Dental Expenses" for further guidance as to what is or is not an Eligible Expense.

CAUTION: Publication 502 addresses medical care expenses a person may deduct on his or her income taxes. Many, ***but not all***, expenses that are tax deductible are also reimbursable under the Health FSA.

6.6 How do I receive my reimbursements under the Health FSA?

(a) **Periodic Reimbursements.** When you incur an expense that is eligible for reimbursement, you submit a claim to the Claims Administrator on a claim form that will be supplied to you. The claim form may be submitted via email, facsimile, mail, or the Claims Administrator's website. The claim form will typically set forth:

(1) the amount, date and nature of the expense;

(2) the name of the person or entity to which the expense was paid;

(3) your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source; and

(4) such other information as the Plan Administrator may require. You may also be required to submit copies of bills or receipts from the provider(s) to support your claim. With respect to claims for over-the-counter drugs and medicines (other than insulin), you must submit either: (i) a copy of the prescription or (ii) a receipt identifying the purchaser (or patient), the date and amount of the purchase, and the Rx number.

If there are enough dollars credited to your Health FSA, you will be reimbursed for your Eligible Expenses according to the schedule established by the Plan Administrator.

Claim Deadline. You may submit claims for reimbursement of Eligible Expenses incurred during the Plan Year for 90 days following the end of that Plan Year. This period following the end of the Plan Year during which claims for reimbursement may be filed is referred to as the "claims run-out period."

(b) **Electronic Payment Card Claims**. If provided, the electronic payment card allows you to pay for Eligible Expenses at the time that you incur the expense. The electronic payment card works as follows:

(1) **You must make an election to use the card**. In order to be eligible for the electronic payment card, you must agree to abide by the terms and conditions of the electronic payment card program as set forth herein and in the electronic payment cardholder agreement (the "Cardholder Agreement"), including agreeing to any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset ineligible claims, etc. You must agree to abide by the terms of the program each Plan Year. A Cardholder Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the program for the new Plan Year. The Cardholder Agreement is part of the terms and conditions of your Plan and this Summary Plan Description.

(2) **The balance of the card is limited**. The balance of the card is limited to the balance of your account.

(3) **The card will be turned off when coverage terminates**. The card will be turned off when your coverage under the Health FSA terminates.

(4) **You must certify proper use of the card**. As specified in the Cardholder Agreement, you certify during the applicable Plan Year that the amounts in your account will only be used for Eligible Expenses (i.e., medical care expenses incurred by you, your spouse, and your tax dependents), that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source, and that you will obtain and retain a third party statement from the health care provider (e.g., receipt, invoice, etc.) each time you swipe the card. Failure to abide by this certification will result in termination of card use privileges.

(5) **Reimbursement under the card is limited to certain places where you purchase health care related items.** Use of the card is limited to merchants who: (i) have health care related merchant category codes other than the drug store or pharmacies merchant category code; (ii) have the drug store or pharmacies merchant category code and with respect to whom 90% of the store's gross receipts during the prior taxable year consisted of items that qualify as expenses for medical care under Section 213(d) of the Code (a "90% pharmacy"); or (iii) participate in an inventory information approval system developed by the card provider that verifies, at the time of purchase, that the goods being purchased constitute medical care.

(6) **You swipe the card at the health care provider like you do any other credit or debit card**. When you incur an Eligible Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under your account (or as otherwise limited by the program) at the time you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment is being made is an Eligible Expense and that you have not been reimbursed by any other source nor will you seek reimbursement from another source.

(7) **You must obtain and retain a receipt/third party statement each time you swipe the card**. You must obtain a third party statement from the health care provider (e.g. receipt, invoice, etc.) each time you swipe the card that includes the following information:

(i) The nature of the expense (e.g. what type of service or treatment was provided). If the expense is for an over the counter drug, the written statement must indicate the name of the drug;

(ii) The date the expense was incurred; and

(iii) The amount of the expense.

Although it is not required to be submitted for all purchases, you must retain this receipt for one year following the close of the Plan Year in which the expense was incurred. Even though payment may be made under the card arrangement, a written third party statement may be required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a letter from

the Claims Administrator if a third party statement is needed. If requested, you must provide the third party statement to the Claims Administrator within 30 days (or such longer period provided in the letter from the Claims Administrator) of the request.

(8) **There are situations where the third party statement will not be required to be provided to the Claims Administrator**. There may be situations in which you will not be required to provide the written statement to the Claims Administrator, including:

(i) **Co-Pay Match**. No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service-providers that have health care related merchant category codes such as physicians, pharmacies, dentists, vision care offices, and hospitals) and the payment matches a specific co-payment you have under one of the Employer's group health plans for the particular service that was provided or a multiple of that co-payment of not more than five (5) times the dollar amount of the co-payment. For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, $20, $30, $40, or $50, you will not be required to provide the third party statement to the Claims Administrator.

(ii) **Previously Approved Claim Match**. No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service-provides that have health care related merchant category codes such as physicians, pharmacies, dentists, vision care offices, and hospitals) and the expense is in the same amount, for the same duration, and at the same provider as a previously approved expense (e.g. the Claims Administrator approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy; each time the card is swiped for subsequent refills at ABC Pharmacy the receipt need not be provided to the Claims Administrator if the expense incurred is the same amount).

(iii) **Provider Match Program.** No third party statement is required to be submitted to the Claims Administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g. your prescription benefits manager) that verifies the amount and nature of the expense and that the expense is an eligible expense.

(iv) **Inventory Information Approval System.** No third party statement is required to be submitted to the Claims Administrator if the electronic payment card is used at a merchant (of any kind) that participates in an inventory information approval system developed by the card provider. Such system verifies, at the time of purchase, that the goods being purchased constitute medical care.

Note: You must still obtain the third party receipt when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Claims Administrator does request it.

(9) **Special rules apply to the use of the electronic payment card to purchase over-the-counter drugs and medicines other than insulin**. Notwithstanding

the rules described above regarding the use of the card to purchase medical care, the card may be used to purchase such over-the-counter drugs and medicines only in the following circumstances:

(i) At any 90% pharmacy if the expense is substantiated after the purchase in accordance with paragraph (7) above.

(ii) At drug stores, pharmacies, non-health care merchants that have pharmacies, and mail order or web-based merchants that sell prescription drugs if (A) the cardholder presents the prescription to the pharmacist; (B) the pharmacist assigns a prescription number and dispenses the over-the-counter drug or medicine in accordance with applicable law; (C) the pharmacy retains a record of the transaction, including the name on prescription, prescription number, date, and the amount of the purchase; (D) the pharmacy's records are accessible by the employer or its agent; (E) the debit card system does not allow over-the-counter drugs or medicines without a prescription number; and (F) the expense is substantiated in accordance with the standard rules described above in paragraphs (vii) and (viii).

(iii) At merchants having healthcare related merchant codes (other than merchants described in item ii above) if the expense is substantiated in accordance with the standard rules described above in paragraphs (vii) and (viii).

Note: If the over-the-counter medicine cannot be purchased with the electronic payment card, it may still be reimbursed using the manual reimbursement procedures described in paragraph (a) above.

(10) **You must pay back any improperly paid claims.** If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator within the applicable time period, the card will be turned off and you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is set forth in the Cardholder Agreement. If you do not repay the Plan within the applicable time period, then the amount of the improperly paid claim may be withheld from your pay (if allowed by applicable law) and/or offset against future eligible claims under the Health FSA. If the amount of the improperly paid claim is not collected in full as described herein, the remaining unpaid amount will be treated as an indebtedness to the Employer.

(11) **You can use either the payment card or the paper claims approach**. You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the paper claims approach discussed above. Claims for which the electronic payment card has been used cannot be submitted as paper claims.

(12) **Your use of the payment card is not a claim**. The use of an electronic payment card does not constitute a "claim" under the claims procedures.

6.7 What limits apply to reimbursements under the Health FSA?

You cannot be reimbursed for any expenses above the amount of your election. You also cannot be reimbursed for any expenses that were incurred before the effective date of the Health FSA, for any expenses incurred before you become a Participant in the Health FSA, or for any expenses incurred after you terminate employment or otherwise cease to be eligible for coverage under the Health FSA, unless coverage is continued.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

Special Rule: A special rule applies to expenses for **orthodontia care**. Such expenses may be reimbursed before the orthodontia care has been provided if you have actually paid the healthcare provider in advance in order to receive the services (e.g., an upfront payment required to receive services).

6.8 What is the Grace Period?

"Grace Period" means the period beginning on January 1 and ending on March 15 each Plan Year. Claims incurred during the Grace Period will be considered to have been incurred during both the preceding Plan Year and the current Plan Year. For example, a claim incurred on March 1, 2018 will be deemed to have been incurred during both the Plan Year running from January 1 through December 31, 2017, and the Plan Year running from January 1 through December 31, 2018.

Claims incurred during the Grace Period will be first allocated to and reimbursed from your account for the preceding Plan Year until such account is exhausted. Thereafter, any such claims will be allocated to and reimbursed from your account for the current Plan Year. Claims incurred during the Grace Period will be allocated based upon the date the claim is received. Once a claim is allocated to an account, no changes, modifications, or adjustments will be allowed. In addition, no adjustment to your election for the current Plan Year may be made based upon the amount of claims incurred during the Grace Period that are reimbursed from the prior Plan Year's account.

NOTE: A claim incurred during the preceding Plan Year and submitted during the claims run-out period will be processed subsequent to a previously submitted claim incurred during the Grace Period, even if your account from the preceding Plan Year is exhausted by reimbursement of the claim incurred during the Grace Period.

6.9 Which plan pays first if I participate in the Employer's health reimbursement arrangement?

If you participate in a health reimbursement arrangement (the "HRA") sponsored by the Employer and you or your spouse or dependent incurs an Eligible Expense that is also eligible for reimbursement under the HRA, then the Eligible Expense must be reimbursed from the HRA first. Once your account balance under the HRA has been exhausted, then an Eligible Expense, or any portion of an Eligible Expense that has not been reimbursed by the HRA, may be reimbursed by this Health FSA.

6.10 What if I am no longer eligible?

If your employment terminates or you otherwise cease to be eligible for coverage under the Health FSA, you may not make any further contributions to your account, and you may not submit claims for reimbursement of expenses incurred after you terminated employment or otherwise ceased to be eligible

for coverage. You may, however, continue to submit claims for reimbursement of expenses incurred before you terminated employment or otherwise ceased to be eligible for coverage for ninety (90) days after the date you ceased to eligible to participate.

NOTE: This rule may differ from the rule applicable to the Dependent Care FSA. Please refer to the prior part of this summary for the rules that apply to the Dependent Care FSA.

6.11 Can coverage be continued?

If your employment terminates or you otherwise cease to be eligible for the Health FSA, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). These continuation rights are described later in this summary.

6.12 Can I carryover my account to the next Plan Year?

No. Any amounts remaining in your account attributable to a particular Plan Year shall be forfeited following the claims run-out period. You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred, on the one hand, and the annual benefit you have elected and paid for, on the other. ***If you do not use it, you lose it.***

(a) In general, carryovers occur within the Health FSA. However, you may receive the carryover to the Plan's Limited Scope Health FSA if: (i) you enroll in the Limited Scope Health FSA for the following plan year, or (ii) you direct the Plan Administrator, by no later than the last day of the Plan Year from which the carryover is to be made and in accordance with procedures adopted by the Plan Administrator, to make the carryover to the Limited Scope Health FSA.

(b) In general, carryovers occur automatically. However, you may elect, in accordance with procedures adopted by the Plan Administrator, to waive the carryover. You must make such an election no later the last day of the Plan Year from which the carryover is to be made.

(c) A carryover does not count against the maximum reimbursement you may receive under the Health FSA for a Plan Year as described above.

Any amounts remaining in your account attributable to a particular Plan Year after the carryover shall be forfeited. You will not be entitled to receive any direct or indirect payment of any amount in your account in excess of the amount that may be carried over to the next Plan Year. ***If you do not use it and it cannot be carried over, you lose it.***

6.13 What if I receive benefits in error?

If a payment for benefits is made by the Health FSA in excess of the benefit to which you are entitled under the Health FSA, the Health FSA has the right to recover such overpayment from the payee. Repayment of an overpayment is a condition of participation in the Cafeteria Plan.

6.14 What if I am subject to a child support order?

The Health FSA shall recognizes child support orders regarding the provision of medical coverage for a child, including orders under the Child Support Performance and Incentive Act of 1998, to the extent required by law. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator.

PART VII.
HSA CONTRIBUTION FEATURE

7.1 What benefits are provided?

The Cafeteria Plan permits you to elect to make contributions to a health savings account ("HSA") under the HSA Contribution Feature. Under the HSA Contribution Feature, you provide a source of pre-tax dollars by entering into a salary reduction arrangement with your Employer. You may also use any available Employer contributions if any are provided. Those pre-tax dollars and the Employer contribution, if any, will be contributed to your HSA. You save Social Security and income taxes on the amount of your salary reduction for HSA contributions.

Your Employer may also make contributions to your HSA. If so, your Employer will provide additional information about the amount and timing of those contributions.

7.2 Am I eligible and how do I become a Participant?

To become a Participant in the HSA Contribution Feature, you must first become a Participant in the Cafeteria Plan. You must also satisfy the eligibility requirements for the HSA Contribution Feature. The HSA Contribution Feature's eligibility requirements are, in general, the same as the eligibility requirements for the Cafeteria Plan as described in Section 1.4. In addition, you must meet certain other requirements in order to participate in the HSA Contribution Feature. To be eligible, you must:

(a) be covered by the Employer's qualifying high deductible health plan; [and]

(b) not have any health coverage through the Employer other than coverage under the Employer's qualifying high deductible health plan; [and]

If you satisfy those requirements, you become a Participant in the HSA Contribution Feature by electing benefits under the HSA Contribution Feature during your initial or subsequent annual enrollment periods.

Caution: The fact that you are eligible to participate in the HSA Contribution Feature does not necessarily mean you are eligible to contribute to an HSA. Other requirements apply. You are responsible for determining whether you have satisfied those other requirements. Please contact your personal tax advisor for additional information.

7.3 What is a Qualifying High Deductible Health Plan?

A "Qualifying High Deductible Health Plan" generally is a health plan providing coverage that meets one of the following requirements:

(a) self-only coverage with a deductible of at least $1,350 (as indexed for inflation) before any reimbursement is made for eligible medical expenses (other than preventive care) and with an annual out-of-pocket limit of not more than $6,650 (as indexed for inflation); or

(b) family coverage with a deductible of at least $2,700 (as indexed for inflation) before any reimbursement is made for eligible medical expenses (other than preventive care), without an embedded individual deductible less than $2,700, and with an annual out-of-pocket limit of not more than $13,300 (as indexed for inflation).

NOTE: A health plan that covers prescription drugs prior to the specified deductible is not a Qualifying High Deductible Health Plan.

7.4 What is Permitted Insurance and Permitted Coverage?

"Permitted Insurance" is:

(a) insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities related to ownership or use of property, or similar liabilities as specified by the IRS;

(b) insurance for specified disease or illness (e.g., cancer insurance); or

(c) insurance that pays a fixed amount per day (or other period) of hospitalization (e.g., hospital indemnity insurance).

"Permitted Coverage" is coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. Permitted coverage includes some medical reimbursement accounts and health reimbursement arrangements (HRAs), such as limited scope medical reimbursement accounts and HRAs (i.e., the Limited Scope Health FSA provided through this Cafeteria Plan), HRAs for which the payment or reimbursement of medical expenses (except expenses for preventive care, dental care, vision care, or long-term care premiums) is suspended, post-deductible medical reimbursement accounts and HRAs, and retirement HRAs. It also includes wellness programs and employee assistance programs that do not provide significant benefits in the nature of non-preventive medical care or treatment.

7.5 What is my HSA?

Your HSA is a health savings account (as defined under the Internal Revenue Code) established by you with a third party trustee/custodian (e.g., bank or insurance company) that is authorized to be the trustee of HSAs. Your Employer does not establish or sponsor your HSA. Furthermore, your Employer does not own your HSA; it is owned by you. However, for administrative convenience, your Employer choose the trustee/custodian to which it will forward contributions.

You may invest the funds in your HSA as allowed by the trustee/custodian of the account. Your Employer has no control of or responsibility for the investment of your HSA.

7.6 What are the limits on the amount of contributions?

The maximum contributions you may make through this HSA Contribution Feature shall be determined in accordance with the following rules:

(a) **Impact of Employer Contributions.** The applicable limit on contributions, as determined in accordance with the following rules, shall be reduced by the amount of contributions made by the Employer to your HSA.

(b) **General Limit.** During a taxable year, contributions to the HSA may not exceed the statutory indexed amount applicable under Code § 223. For 2018, those amounts are: $3,450 if you have self-only coverage under the HDHP or $6,900 if you have family HDHP coverage.

(c) **Catch Up Contributions.** An additional "catch-up" amount (determined on a monthly basis) can be contributed if you attain age 55 before the close of the taxable year.

(d) **Pro-rated Limit if Not Eligible on December 1st.** If you cease to satisfy the eligibility requirements described above prior to December 1st of any calendar year, your contribution limit for that year shall be determined by multiplying 1/12 of the applicable limit describe in paragraphs (a) and (b) by the number of months for which you satisfied the eligibility requirements described above (as of the first day of the month).

Note: Your Employer is not be required to take an corrective action in the event the amount of your HSA contributions made prior to the date on which you cease to satisfy the eligibility requirements described above exceed this pro-rated limit.

(e) **Special Rule if Eligible on December 1st.** If you become eligible to make contributions under this HSA Contribution Feature (as provided above) during the taxable year and you are eligible on December 1st of such year, you are deemed to have been eligible for each month in such taxable year and may make HSA contributions up to the full annual limit. This special rule applies to all contributions made during the applicable taxable year, including contributions made prior to or after December 1st.

Example: If you become eligible to make HSA contributions on July 1st and you remain eligible through December 1st, you may begin making contributions to your HSA through this Plan on July 1st at a rate pursuant to which the full annual contribution will have been made by the end of the taxable year.

Caution: The fact that you are participating in the HSA Contribution Feature does not necessarily mean you are eligible to contribute to an HSA. Other requirements apply. If you are ineligible for HSA contributions for reasons unknown to your Employer, your contributions under this HSA Contribution Feature may exceed the amount of contributions you are allowed to make to an HSA. You are responsible for determining whether you are eligible for HSA contributions and the limit on your contributions for any given year. Please contact your personal tax advisor for additional information.

7.7 What happens if my contributions exceed the contribution limit?

If the contributions to your HSA exceed the applicable maximum contribution limit for a year, the excess contributions typically will be included in your income and an excise tax will be imposed upon them. You will also be taxed on any earnings earned on the excess amounts. However, you can avoid the excess tax if you take a distribution of the excess contributions (and the net income attributable to the excess contribution) before the last day (including extensions) for filing your federal income tax return.

7.8 What are the tax consequences of the HSA Contribution Feature?

The contributions made under this HSA Contribution Feature will not be included in your gross income, unless they exceed the applicable maximum contribution limit as discussed above.

7.9 What are the rules regarding distributions from my HSA?

Your Employer has no control over or involvement with distributions made from your HSA. Your Employer does not substantiate expenses for which such distributions are made. Information regarding the procedure for obtaining distributions and the consequences of taking distributions is available from the trustee/custodian of your HSA.

7.10 When does my participation end?

Participation in the HSA Contribution Feature ends upon the earlier of the date your participation in Plan ceases or the date you no longer satisfy the eligibility requirements described above. However, you

need not be a participant in the HSA Contribution Feature (or be employed by the Employer) in order to obtain distributions from your HSA. In addition, you may make contributions to your HSA outside this Cafeteria Plan, provided you are eligible to do so under IRS rules, after you have left employment with the Employer or have ceased to be a participant in the Cafeteria Plan.

NOTE: This HSA Contribution Feature is ***not*** a group health plan for purposes of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), the Family and Medical Leave Act (FMLA), and the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). COBRA, FMLA, and USERRA do not apply to this HSA Contribution Feature. However, COBRA, FMLA, and USERRA may apply to the Qualifying High Deductible Health Plan.

7.11 Can the contributions made to my HSA be forfeited?

No, once the contributions have been deposited in your HSA, you will have a nonforfeitable interest in the funds. You will be free to request a distribution of the funds or to move them to another provider of HSAs, to the extent allowed by law.

7.12 What are the reporting requirements?

Your Employer is responsible for reporting contributions made to your HSA through this HSA Contribution Feature on your Form W-2. You are also responsible for reporting contributions to your HSA, and for reporting distributions from your HSA, on appropriate forms available from the IRS.

PART VIII.
LIMITED SCOPE HEALTH FLEXIBLE SPENDING ACCOUNT

8.1 What benefits are provided?

The Cafeteria Plan permits you to elect to receive reimbursement for some or all of your uninsured medical and dental expenses under the Limited Scope Health Flexible Spending Account ("Limited Scope Health FSA"). Under the Limited Scope Health FSA, you provide a source of pre-tax dollars by entering into a salary reduction agreement with your Employer. Those pre-tax dollars will be used to reimburse you for your Eligible Expenses. You save Social Security and income taxes on the amount of your salary reduction for medical expenses.

The coverage provided through the Limited Scope Health FSA is subject to the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Limited Scope Health FSA is intended to be an excepted benefit under the HIPAA portability rules. Accordingly, neither the HIPAA portability rules nor the preventative care mandate of the Patient Protection and Affordable Care Act, as amended, apply to the Limited Scope Health FSA.

8.2 How do I become a Participant?

To become a Participant in the Limited Scope Health FSA, you must first become a Participant in the Cafeteria Plan. You must also satisfy the eligibility requirements for the Limited Scope Health FSA. The Limited Scope Health FSA's eligibility requirements are the same as the eligibility requirements for the Cafeteria Plan as described in Section 1.4. If you satisfy those requirements, you become a Participant in the Limited Scope Health FSA by electing benefits under the Limited Scope Health FSA during your initial or subsequent annual enrollment periods.

NOTE: Participation in this Limited Scope Health FSA will not make you ineligible to participate in the HSA Contribution Feature, and will not make you and any of your dependents covered by the Limited Scope Health FSA ineligible to make or receive contributions to a health savings account.

8.3 What is my limited scope medical expense account?

If you elect benefits under the Limited Scope Health FSA, an account will be established in your name to keep a record of the benefits to which you are entitled. When you complete the election form, you specify the amount of benefits you wish to receive. These benefits may be funded by allocation of any available and, to the extent the Employer contribution is insufficient, with pre-tax dollars through salary reduction contributions.

The full amount of your election under the Limited Scope Health FSA will be available at any time during the Plan Year, reduced by the amount of prior reimbursements under the Limited Scope Health FSA received during the Plan Year.

The Limited Scope account is a bookkeeping account only. Benefits under the Limited Scope Health FSA are paid from the Employer's general assets. There is no trust.

8.4 What are the maximum reimbursements I may receive?

The maximum amount of medical expense reimbursements is the IRS Maximum defined at time of open enrollment per Plan Year. For a short Plan Year, the maximum is unchanged for the number of pay periods remaining in the Plan Year. If you enter the plan mid-year, this maximum amount will be unchanged for the number of pay periods remaining in the Plan Year.

8.5 What is an "Eligible Expense"?

(a) **Generally**. An "Eligible Expense," in most situations, means an expense; (1) for which you could have claimed a medical expense deduction on an itemized federal income tax return; (2) for which you have not otherwise been reimbursed from health coverage, or some other source; and (3) that is either: (i) incurred during the applicable Plan Year, but after the applicable "minimum annual deductible" has been satisfied, for any type of care; incurred at any time during the applicable Plan Year for dental or vision care. Eligible Expenses include expenses incurred by you and your "spouse" and "dependents."

"*Preventive care*" includes periodic health examinations (e.g., annual physicals, routine prenatal and well-child care), immunizations, tobacco cessation and obesity weight-loss programs, and screening services that are not for the treatment of an existing illness, injury, or condition. Preventive care also includes treatment of a related condition during the preventive care service or screening. Preventive Care also includes preventive drugs/medications (e.g. drugs/medications taken by a person who has developed risk factors for a disease that has not yet manifested itself or taken to prevent the reoccurrence of a disease).

"*Minimum annual deductible*" means the applicable minimum annual deductible for a high deductible health plan under Section 223(c)(2)(A)(i) of the Internal Revenue Code. This amount typically changes from year to year. If you have either a Spouse or Dependents during the Plan Year, the minimum annual deductible will be the minimum deductible for family coverage. If you have no Spouse or Dependents during the Plan Year, the minimum annual deductible will be the minimum deductible for single coverage. For purposes of determining whether the minimum annual deductible has been satisfied, only expenses that count toward the deductible under high deductible medical plan will be taken into account.

For purposes of this Limited Scope Health FSA, **"spouse"** means a person to whom you are legally married in accordance with applicable state law.

For purposes of this Limited Scope Health FSA, **"dependent"** generally includes an individual who satisfies the requirements of paragraph (1), (2), or (3) below:

(1) An individual who:

(i) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption); and

(ii) will not attain age 27 during the relevant calendar year.

(2) An individual who:

(i) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;

(ii) has the same principal place of abode as you for at least one-half of the relevant year;

(iii) will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled;

(iv) did not provide over half of his/her own support during the relevant year;

(v) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;

(vi) is younger than you (unless he/she is permanently and totally disabled); and

(vii) does not file a joint tax return with his or her spouse.

(3) An individual who:

(i) is your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent's ancestor), stepparent, brother or sister's son or daughter, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household;

(ii) has received more than one-half of his/her support from you during the relevant year;

(iii) is not your qualifying child or the qualifying child of anyone else (i.e., does not satisfy the requirements of paragraph (1) above with respect to any person); and

(iv) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

NOTE: The definition "dependent" is different than the definition applicable under the Internal Revenue Code for purposes of identifying who you may claim as an exemption on your federal income tax return. Furthermore, an individual eligible for dependent coverage under the Group Medical Plan is not necessarily a "dependent" for purposes of the Limited Scope Health FSA. Additional special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

(b) **Special rules for over-the-counter items.** Eligible Expense *includes* certain over-the-counter items that constitute medical care (under Section 213(d) of the Internal Revenue Code) even though a tax deduction is not available. Over-the-counter drugs and medicines (other than insulin) require a prescription to be an Eligible Expense. For this purpose, a "prescription" means a written or electronic order for a medicine or drug (1) that meets the legal requirements of a prescription in the state in which the medical expense is incurred, and (2) that is issued by an individual who is legally authorized to issue a prescription in that state.

(c) **Exceptions**. Despite the general rule stated above, Eligible Expense ***does not*** include premiums for any group or individual health plan or long term care coverage.

IMPORTANT: Please review the "Dental & Orthodontic Care" and "Vision Care" sections of Exhibit A—Eligible Medical Care Expenses. You are also encouraged to consult your personal tax advisor or IRS Publication 502, "Medical and Dental Expenses" for further guidance as to what is or is not an Eligible Expense.

CAUTION: Publication 502 addresses medical care expenses a person may deduct on his or her income taxes. Many, ***but not all***, dental, vision, and preventive care expenses that are tax deductible are also reimbursable under the Limited Scope Health FSA.

8.6 How do I receive my reimbursements under the Limited Scope Health FSA?

(a) **Periodic Reimbursements.** When you incur an expense that is eligible for reimbursement, you submit a claim to the Claims Administrator on a claim form that will be supplied to you. The claim form may be submitted via email, facsimile, mail, or the Claims Administrator's website. The claim form will typically set forth:

(1) the amount, date and nature of the expense,

(2) the name of the person or entity to which the expense was paid,

(3) your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source, and

(4) such other information as the Plan Administrator may require. You may also be required to submit copies of bills or receipts from the provider(s) to support your claim. With respect to claims for over-the-counter drugs and medicines (other than insulin), you must submit either: (i) a copy of the prescription or (ii) a receipt identifying the purchaser (or patient), the date and amount of the purchase, and the Rx number.

If there are enough dollars credited to your Limited Scope Health FSA, you will be reimbursed for your Eligible Expenses according to the schedule established by the Plan Administrator.

Claims Deadline. You may submit claims for reimbursement of Eligible Expenses incurred during the Plan Year for 90 days following the end of Plan Year for that Plan Year. This period following the end of the Plan Year during which claims for reimbursement may be filed is referred to as the "claims run-out period."

(b) **Electronic Payment Card Claims**. The electronic payment card allows you to pay for Eligible Expenses at the time that you incur the expense. The electronic payment card works as follows:

(1) **You must make an election to use the card**. In order to be eligible for the electronic payment card, you must agree to abide by the terms and conditions of the electronic payment card program as set forth herein and in the electronic payment cardholder agreement (the "Cardholder Agreement"), including agreeing to any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset ineligible claims, etc. You must agree to abide by the terms of the program each Plan Year. A Cardholder Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the program for the new Plan Year. The Cardholder Agreement is part of the terms and conditions of your Plan and this Summary Plan Description.

(2) **The balance of the card is limited**. The balance of the card is limited to the balance of your account.

(3) **The card will be turned off when coverage terminates**. The card will be turned off when your coverage under the Limited Scope Health FSA terminates.

(4) **You must certify proper use of the card**. As specified in the Cardholder Agreement, you certify during the applicable Plan Year that the amounts in your account will only be used for Eligible Expenses (i.e., medical care expenses incurred by you, your spouse, and your tax dependents), that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source, and that you will obtain and retain a third party statement from the health care provider (e.g., receipt, invoice, etc.) each time you swipe the card. Failure to abide by this certification will result in termination of card use privileges.

(5) **Reimbursement under the card is limited to certain places where you purchase health care related items.** Use of the card is limited to merchants who: (i) have health care related merchant category codes other than the drug store or pharmacies merchant category code; (ii) have the drug store or pharmacies merchant category code and with respect to whom 90% of the store's gross receipts during the prior taxable year consisted of items that qualify as expenses for medical care under Section 213(d) of the Code (a "90% pharmacy"); or (iii) participate in an inventory information approval system developed by the card provider that verifies, at the time of purchase, that the goods being purchased constitute medical care.

(6) **You swipe the card at the health care provider like you do any other credit or debit card**. When you incur an Eligible Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under your Limited Scope account (or as otherwise limited by the program) at the time you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment is being made is an Eligible Expense and that you have not been reimbursed by any other source nor will you seek reimbursement from another source.

(7) **You must obtain and retain a receipt/third party statement each time you swipe the card**. You must obtain a third party statement from the health care provider (e.g. receipt, invoice, etc.) each time you swipe the card that includes the following information:

(i) The nature of the expense (e.g. what type of service or treatment was provided). If the expense is for an over the counter drug, the written statement must indicate the name of the drug;

(ii) The date the expense was incurred; and

(iii) The amount of the expense.

Although it is not required to be submitted for all purchases, you must retain this receipt for one year following the close of the Plan Year in which the expense was incurred. Even though payment may be made under the card arrangement, a written third party statement may be required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a letter from

the Claims Administrator if a third party statement is needed. If requested, you must provide the third party statement to the Claims Administrator within 30 days (or such longer period provided in the letter from the Claims Administrator) of the request.

(8) **There are situations where the third party statement will not be required to be provided to the Claims Administrator**. There may be situations in which you will not be required to provide the written statement to the Claims Administrator, including:

(i) **Co-Pay Match**. No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service-providers that have health care related merchant category codes such as physicians, pharmacies, dentists, vision care offices, and hospitals) and the payment matches a specific co-payment you have under any of the Employer's group health plans for the particular service that was provided or a multiple of that co-payment of not more than five (5) times the dollar amount of the co-payment. For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, $20, $30, $40, or $50, you will not be required to provide the third party statement to the Claims Administrator.

(ii) **Previously Approved Claim Match**. No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service-provides that have health care related merchant category codes such as physicians, pharmacies, dentists, vision care offices, and hospitals) and the expense is in the same amount, for the same duration, and at the same provider as a previously approved expense (e.g. the Claims Administrator approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy; each time the card is swiped for subsequent refills at ABC Pharmacy the receipt need not be provided to the Claims Administrator if the expense incurred is the same amount).

(iii) **Provider Match Program.** No third party statement is required to be submitted to the Claims Administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g. your prescription benefits manager) that verifies the nature and amount of the expenses and that the expense is an eligible expense.

(iv) **Inventory Information Approval System**. No third party statement is required to be submitted to the Claims Administrator if the electronic payment card is used at a merchant (of any kind) that participates in an inventory information approval system developed by the card provider. Such system verifies, at the time of purchase, that the goods being purchased constitute medical care.

Note: You must still obtain the third party receipt when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Claims Administrator does request it.

(9) **Special rules apply to the use of the electronic payment card to purchase over-the-counter drugs and medicines other than insulin**. Notwithstanding

the rules described above regarding the use of the card to purchase medical care, the card may be used to purchase such over-the-counter drugs and medicines only in the following circumstances:

(i) At any 90% pharmacy if the expense is substantiated after the purchase in accordance with paragraph (7) above.

(ii) At drug stores, pharmacies, non-health care merchants that have pharmacies, and mail order or web-based merchants that sell prescription drugs if (A) the cardholder presents the prescription to the pharmacist; (B) the pharmacist assigns a prescription number and dispenses the over-the-counter drug or medicine in accordance with applicable law; (C) the pharmacy retains a record of the transaction, including the name on prescription, prescription number, date, and the amount of the purchase; (D) the pharmacy's records are accessible by the employer or its agent; (E) the debit card system does not allow over-the-counter drugs or medicines without a prescription number; and (F) the expense is substantiated in accordance with the standard rules described above in paragraphs (vii) and (viii).

(iii) At merchants having healthcare related merchant codes (other than merchants described in item ii above) if the expense is substantiated in accordance with the standard rules described above in paragraphs (vii) and (viii).

Note: If the over-the-counter medicine cannot be purchased with the electronic payment card, it may still be reimbursed using the manual reimbursement procedures described in paragraph (a) above.

(10) **You must pay back any improperly paid claims.** If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator within the applicable time period, the card will be turned off and you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is set forth in the Cardholder Agreement. If you do not repay the Plan within the applicable time period, then the amount of the improperly paid claim may be withheld from your pay (if allowed by applicable law) and/or offset against future eligible claims under the Health FSA. If the amount of the improperly paid claim is not collected in full as described herein, the remaining unpaid amount will be treated as an indebtedness to the Employer.

(11) **You can use either the payment card or the paper claims approach**. You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the paper claims approach discussed above. Claims for which the electronic payment card has been used cannot be submitted as paper claims.

(12) **Your use of the payment card is not a claim**. The use of an electronic payment card does not constitute a "claim" under the claims procedures.

8.7 What limits apply to reimbursements under the Limited Scope Health FSA?

You cannot be reimbursed for any expenses above the amount of your election. You also cannot be reimbursed for any expenses that were incurred before the effective date of the Limited Scope Health

FSA, for any expenses incurred before you become a Participant in the Limited Scope Health FSA, or for any expenses incurred after you terminate employment or otherwise cease to be eligible for coverage under the Limited Scope Health FSA, unless coverage is continued.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

Special Rule: A special rule applies to expenses for **orthodontia care**. Such expenses may be reimbursed before the orthodontia care has been provided if you have actually paid the healthcare provider in advance in order to receive the services (e.g., an upfront payment required to receive services).

8.8 What is the Grace Period?

"Grace Period" means the period beginning on January 1 and ending on March 15 each Plan Year. Claims incurred during the Grace Period will be considered to have been incurred during both the preceding Plan Year and the current Plan Year. For example, a claim incurred on March 1, 2018 will be deemed to have been incurred during both the Plan Year running from January 1 through December 31, 2017, and the Plan Year running from January 1 through December 31, 2018.

Claims incurred during the Grace Period will be first allocated to and reimbursed from your Limited Scope account for the preceding Plan Year until such account is exhausted. Thereafter, any such claims will be allocated to and reimbursed from your Limited Scope account for the current Plan Year. Claims incurred during the Grace Period will be allocated based upon the date the claim is received. Once a claim is allocated to an account, no changes, modifications, or adjustments will be allowed. In addition, no adjustment to your election for the current Plan Year may be made based upon the amount of claims incurred during the Grace Period that are reimbursed from the prior Plan Year's account.

NOTE: A claim incurred during the preceding Plan Year and submitted during the claims run-out period will be processed subsequent to a previously submitted claim incurred during the Grace Period, even if your Limited Scope account from the preceding Plan Year is exhausted by reimbursement of the claim incurred during the Grace Period.

8.9 Which plan pays first if I participate in the Employer's health reimbursement arrangement?

If you participate in a health reimbursement arrangement (the "HRA") sponsored by the Employer and you or your spouse or dependent incurs an Eligible Expense that is also eligible for reimbursement under the HRA, then the Eligible Expense must be reimbursed from the HRA first. Once your account balance under the HRA has been exhausted, then an Eligible Expense, or any portion of an Eligible Expense that has not been reimbursed by the HRA, may be reimbursed by this Limited Scope Health FSA.

8.10 What if I am no longer eligible?

If your employment terminates, or you otherwise cease to be eligible for coverage under the Limited Scope Health FSA, your benefits under the Limited Scope Health FSA stop. You may not make any further contributions to your Limited Scope account, and you may not submit claims for reimbursement of expenses incurred after you terminated employment or otherwise ceased to be eligible for coverage. You may, however, continue to submit claims for expenses incurred before you terminated employment or otherwise ceased to be eligible for coverage until the expiration of the claims run out period following the end of the Plan Year described in Section 4.5.

NOTE: This rule may differ from the rule applicable to the Dependent Care FSA. Please refer to the part of this summary describing the Dependent Care FSA for the rules that apply to the Dependent Care FSA.

8.11 Can coverage be continued?

If your employment terminates or you otherwise cease to be eligible for the Limited Scope Health FSA, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). These continuation rights are described later in this summary.

8.12 Can I carryover my Limited Scope account to the next Plan Year?

No. Any amounts remaining in your Limited Scope account attributable to a particular Plan Year shall be forfeited following the claims run-out period described in Section 4.5. You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual dependent care expenses you have incurred, on the one hand, and the annual benefit you have elected and paid for, on the other. ***If you do not use it, you lose it.***

The Limited Scope Health FSA shall recognizes child support orders regarding the provision of medical coverage for a child, including orders under the Child Support Performance and Incentive Act of 1998, to the extent required by law. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator.

PART IX.
CONTINUATION COVERAGE

9.1 What are my continuation rights under COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires most employers with twenty (20) or more employees to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premium for the continuation coverage. The Group Medical Plan, Group Dental Plan, Group Term Life and AD&D Plan, shall be operated consistent with COBRA. Please refer to the Employer's COBRA policies and procedures contained in a separate document and is incorporated by reference into this summary. This document is available to you upon request, at no charge.

9.2 What special COBRA rules apply to the Health FSA, Limited Scope Health FSA and Health Reimbursement Account?

Modified COBRA continuation coverage rules apply to the Health FSA, Limited Scope Health FSA and Health Reimbursement Account. Continuation coverage is generally available on the same terms and conditions that apply to the group health plans. There are, however, several differences. For example, the beginning date of the continuation coverage is earlier. If elected, continuation coverage begins on the date of the qualifying event. Furthermore, the maximum duration of the continuation coverage is much shorter. If the account is "underspent" at the time of the loss, the maximum duration of COBRA is through the end of the Plan Year in which the loss takes place. If the account is "overspent" at the time of the loss, there is no requirement that COBRA be offered.

Underspent. An account is UNDERSPENT when the remaining annual limit (elected annual limit minus expenses reimbursed as of date of COBRA qualifying event) is greater than the maximum COBRA premium (sum of monthly contributions for the rest of the plan year plus 2%) that can be charged for the rest of the plan year.

Overspent. An account is OVERSPENT when the remaining annual limit (elected annual limit minus expenses reimbursed as of date of COBRA qualifying event) is less than the maximum COBRA premium (sum of monthly contributions for the rest of the plan year plus 2%) that can be charged for the rest of the plan year.

9.3 What are my continuation rights under USERRA?

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under USERRA for a period of up to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States. This continuation right is similar to, and runs concurrent with, your continuation right under COBRA (if any). The Group Medical Plan, Group Dental Plan, Group Term Life and AD&D Plan, Flexible Spending Account, Limited Scope Flexible Spending Account, Dependent Care Flexible Spending Account and HSA Contribution Feature shall be operated consistent with USERRA and pursuant to USERRA policies and procedures contained in a separate document and is incorporated by reference into this Cafeteria Plan. This document is available to you upon request, at no charge.

9.4 What are my continuation and/or conversion rights for group health plan coverage under state law?

Some, but not all, states require continuation and/or conversion of group health insurance (including medical, dental, and vision insurance) upon certain events. If provided under applicable state law, your continuation and/or conversion rights, and the rights of those who are covered through you, are described in the separate materials that have been provided to you either directly by the carrier (the insurance company) or by your Employer. If you have not been provided this information, you should contact the Plan Administrator.

PART X.
FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 ("FMLA") imposes certain obligations on employers with fifty (50) or more employees. This Cafeteria Plan shall be administered in a manner consistent with the FMLA and the Employer's FMLA Policy required thereunder. You will be provided with a complete explanation of FMLA rights and responsibilities. In the event you are entitled and elect to continue coverage under the Plan during an FMLA leave, such coverage shall terminate if your FMLA leave expires and you do not return to work.

NOTE: You should contact your Employer regarding any FMLA questions. The Claims Administrator does not have authority to make these decisions.

PART XI.
ADMINISTRATIVE INFORMATION

Plan:

Plan Name:	South St. Paul Schools Cafeteria Plan
Plan Type:	Section 125 Cafeteria Plan

Employer, Plan Administrator, and Agent for Service of Legal Process:

Name:	South St. Paul Schools
Address:	104 5th Ave South
City, State Zip:	South St. Paul, MN 55075
Phone/Fax Number:	651-457-9473 / 651-457-9485
EIN:	41-60000790
Contact Person:	Cathy Miller

Claims Administrator:

Name:	«Company_Name»
Address:	«Address_Line_1» «Address_Line_2»
City, State Zip:	«City», «State» «ZIP_Code»
Phone/Fax Number:	«Phone»/ «Fax_Number»

PLAN NAME	PLAN TYPE
South St. Paul Schools Cafeteria Plan	Cafeteria Plan
South St Paul Schools Dependent Care Flexible Spending Account	Dependent Care Assistance Plan
South St Paul Schools Health Flexible Spending Account	FSA
South St Paul Schools Limited Scope Health Flexible Spending Account	LPFSA

This Plan does not have a trust; therefore, there are no trustees.

EXHIBIT A
Eligible Medical Care Expenses

Health FSA. Medical and dental expenses that qualify as expenses for medical care under Internal Revenue Service rules generally qualify as Eligible Expenses for reimbursement under the Health FSA. Those may take the form of co-pays, deductibles, and medical expenses not covered by other insurance. Often expenses that qualify for deductions under IRS rules are Eligible Expenses, but in some instances expenses that are deductible will not be reimbursable and expenses that are not deductible will be reimbursable. Some specific examples are identified below. The following is not an exhaustive list and there are other expenses that are eligible if they satisfy the IRS rules.

Limited Scope Health FSA. Only a limited number of the following expenses are Eligible Expenses for reimbursement under the Limited Scope Health FSA. The expenses must be for dental, vision, or preventive care. Dental care expenses are listed under the "Dental & Orthodontic Care" section. Vision care expenses are listed under the "Vision Care" section. Expenses for preventive care may be found in any of the following sections, but they must satisfy the definition of "preventive care" included in Limited Scope Health FSA.

Dental & Orthodontic Care

Allowable expenses:
- Dental treatment
- Artificial teeth/dentures
- Braces, orthodontic devices

Expenses specifically disallowed by the IRS or courts:
- Teeth whitening
- Toothbrushes and toothpaste, even if special type is recommended by dentist

Therapy Treatments

Allowable expenses:
- X-ray treatments
- Treatment for alcoholism or drug dependency
- Legal sterilization
- Acupuncture
- Vaccinations
- Hair transplant to treat specific medical conditions
- Physical therapy (as a medical treatment)
- Fee to use swimming pool for exercises prescribed by physician to alleviate specific medical condition such as rheumatoid arthritis
- Speech therapy
- Smoking cessation programs and prescribed drugs to alleviate nicotine withdrawal

Expenses specifically disallowed by the IRS or courts:
- Physical treatments unrelated to a specific health problem (e.g., massage for general well being)
- Any illegal treatment
- Cosmetic surgery
- Treatment for baldness (unless it is for a specific medical condition and not for cosmetic purposes)
- Electrolysis (unless it is for a specific medical condition and not for cosmetic purposes)

Fees/Services

Allowable expenses:
- Physician's fees and hospital services
- Nursing services for care of a specific medical ailment
- Cost of a nurse's room and board if paid by the taxpayer where nurse's services qualify
- Social Security tax paid with respect to wages of a nurse where nurse's services qualify
- Services of chiropractors
- Christian Science practitioner fees
- Diagnostic tests

Expenses specifically disallowed by the IRS or courts:
- Payments to domestic help, companion, babysitter, chauffeur, etc. who primarily render services of a non-medical nature
- Nursemaids or practical nurses who render general care for healthy infants
- Fees for exercise, athletic, or health club membership when there is no specific health reason for needing membership
- Marriage counseling provided by clergyman

Hearing Expenses

Allowable expenses:
- Hearing aids and hearing aid batteries
- Hearing aid repair
- Special telephone equipment

Medicine and Drugs

Allowable expenses:

- Medicine and drugs that require a prescription
- Insulin
- Prescribed over the counter medicine and drugs when used to alleviate or treat personal injuries or sickness (including antacids, antihistamines, aspirin/pain relievers, bandages, cold medicines, acne medicine, etc.)

Expenses specifically disallowed by the IRS or courts:

- Medicine and drugs for personal, general health, or cosmetic purposes
- Dietary supplements if for general health

Medical Equipment

Allowable expenses:

- Blood sugar test kits
- Wheelchair or autoette (cost of operating/maintaining)
- Crutches (purchased or rented)
-
- Special mattress & plywood boards prescribed to alleviate arthritis
- Oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition
- Artificial limbs
- Support hose (if medically necessary)
- Wigs (where necessary to mental health of individual who loses hair because of disease)
- Excess cost of orthopedic shoes over cost of ordinary shoes
- Breast pumps for nursing mothers

Expenses specifically disallowed by the IRS or courts:

- Wigs, when not medically necessary for mental health
- Vacuum cleaner purchased by an individual with dust allergy
- Mechanical exercise device not specifically prescribed by physician

Physicals

Allowable expenses:

- Physicals and other well visits
- Immunizations

Expenses specifically disallowed by the IRS or courts:

- Physicals for employment purposes

Vision Care

Allowable expenses:

- Optometrist's or ophthalmologist's fees
- Eyeglasses and prescription sunglasses
- Insurance for replacement of lost or damaged contact lenses
- Contact lens and contact lens solutions
- Laser eye surgery

Assistance for the Handicapped

Allowable expenses:

- Cost of guide for a blind person
- Cost of note-taker for a deaf child in school
- Cost of Braille books and magazines in excess of cost of regular editions
- Seeing eye dog (cost of buying, training and maintaining)
- Household visual alert system for deaf person
- Excess costs of specifically equipping automobile for handicapped person over cost of ordinary automobile; device for lifting handicapped person into automobile
- Special devices, such as tape recorder and typewriter, for a blind person

Psychiatric Care

Allowable expenses:

- Services of psychotherapists, psychiatrists and psychologists

Expenses specifically disallowed by the IRS or courts:

- Psychoanalysis undertaken to satisfy curriculum requirements of a student

Miscellaneous Charges

Allowable expenses:

- X-rays
- Expenses for services connected with donating an organ
- Excess cost of medically prescribed diet
- The cost of a medically prescribed weight loss program
- Breast reconstructive surgery following mastectomy as part of treatment for cancer
- Contraceptives
- Fertility treatments
- Medical records charges
- Bandages
- Lactation supplies for nursing mothers
- Cost of transportation primarily for and essential to medical care (e.g., the expense of traveling to and from a medical service provider)

Expenses specifically disallowed by the IRS or courts:

- Expenses of divorce when doctor or psychiatrist recommends divorce
- Cost of toiletries, cosmetics, and sundry items (e.g., soap, toothbrushes)
- Cost of special foods taken as a substitute for regular diet, when the special diet is not medically necessary or taxpayer cannot show cost in excess of cost of a normal diet
- Maternity clothes
- Diaper service
- Distilled water purchased to avoid drinking fluoridated county water supply
- Installation of power steering in automobile
- Pajamas purchased to wear in hospital
- Mobile telephone used for personal calls as well as calls to physician
- Union dues for sick benefits for members
- Contributions to state disability funds
- Auto insurance providing medical coverage for all persons injured in or by the taxpayer's automobile, where amounts allocable to taxpayer and dependent is not stated separately
- Long-term care services
- Funeral expenses

Insurance

Allowable expenses:

- None

Expenses specifically disallowed by the IRS or courts:

- Health insurance premiums (including individual and non-employer sponsored coverage and continuation premiums)
- Long term care insurance premiums

E X H I B I T B
DEPENDENT CARE FSA v. Claiming Dependent Care Tax Credit

EXAMPLE – MARRIED EMPLOYEE WITH TWO CHILDREN EARNING $48,000	**DEPENDENT CARE FSA**	**CLAIMING DEPENDENT CARE TAX CREDIT**
1. W-2 Gross Wages (both spouses combined)	$48,000.00	$48,000.00
2. DEPENDENT CARE FSA Salary Reductions	-$5,000.00	$0.00
3. W-2 Gross Wages	$43,000.00	$48,000.00
4. Standard Deduction	-$11,400.00	-$11,400.00
5. Exemptions (4 individuals x $3,650)	-$14,600.00	-$14,600.00
6. Taxable Income (line 3 minus lines 4 and 5)	$17,000.00	$22,000.00
Calculation of Disposable Income		
7. W-2 Gross Wages	$43,000.00	$48,000.00
8. Out-of-Pocket Dependent Care Expenses Not Reimbursed by DEPENDENT CARE FSA	$0.00	-$5,000.00
9. FICA Tax (calculated separately on each spouse's share of the wages)	-$3,290.00	-$3,672.00
10. Federal Income Tax (line 6 @ tax schedule)	-$1,713.00	-$2,463.00
11. Non-Refundable Dependent Care Tax Credit	$0.00	$1,000.00
12. Non-Refundable Child Tax Credit	$1,713.00	$1,463.00
13. Refundable Earned Income Tax Credit	$500.00	$0.00
14. Refundable Additional Child Tax Credit	$287.00	$537.00
15. Refundable Making Work Pay Credit	$800.00	$800.00
15. **Disposable Income** (line 7 minus lines 8-10 plus lines 11-14)	**$41,297.00**	**$40,665.00**

Caution: This is just an illustration of how a comparison should be done and how many factors are involved. Each person's situation is different. You are encouraged to consult your personal tax adviser or IRS Publication 503, "Child and Dependent Care Expenses" for further guidance.